ADVANCED SPECIALTY ANESTHESIA, LLC

REQUEST FOR ANESTHESIA SERVICES

Email to: referral@asasleep.com Fax: 785-422-5477

Referring Provider Office please complete below section:

Referring office/doctor: _____ Sedation date scheduled: ____/____/____ or (TBD)To Be Determined

Estimated Treatment Time: (***please circle***) 1 hr. 90 min. 2 hr. 2 hr. 30 min. Other:_____

*Please provide copy of dental treatment plan in packet.

Patient Information

First Name:_____ Last Name:_____ (Nickname):_____

Date of Birth: ____/____/____ Sex: M/ F Preferred Language_____

Home Address :_____ City:_____ State_____ Zip _____

Cell Phone:_____ Alternate Phone :_____ Ok to contact by Text message: Y / N

- Does patient reside in a facility/nursing home? Yes/No If yes, Name/Phone: _____
- Is the patient in Foster Care? Yes/No If Yes, Foster Care Name/Phone: _____

Parent/Guardian Information (patients 18 years of age or younger)

First Name:_____ Last Name:_____ Relationship to Patient:_____

Home Address (if different from patient)_____ City:_____ State_____ Zip _____

Phone Number :_____ Email Address:_____

Medical Insurance Information -Please provide copy of card

Insurance Company: _____ ID Number: _____

Policyholder's Name: _____ Policyholder DOB: _____

I hereby give permission to Advanced Specialty Anesthesia, LLC to:

-To leave a message regarding information relevant to anesthesia services.
-Discuss and request necessary medical records from any physician facility named below:

Primary Care Physician:_____

Hospital/Other:_____

Patient/Guardian Signature: _____ Printed Name:_____ Date: _____

Attach: copy of the medical card, pre-anesthesia health history, and patients current physical

Permission signature by patient/guardian is valid for 1 year from signature date.