

## Anesthesia Supplement Questionnaire

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- A. Type of anesthesia/ analgesia used when treating patients under conscious sedation (please specify):
1. Inhalation: \_\_\_\_\_  
Nitrous Oxide (when used with other anesthetic/analgesia agents): \_\_\_\_\_
  2. Intravenous: \_\_\_\_\_
  3. Intramuscular (including submucosal): \_\_\_\_\_
  4. Combination: \_\_\_\_\_
  5. What location is conscious sedation procedure performed? \_\_\_\_\_
- B. Type of anesthesia/analgesia used when treating patients under general anesthesia. Including deep sedation (please specify): \_\_\_\_\_
1. Inhalation: \_\_\_\_\_  
Nitrous Oxide (when used with other anesthetic/analgesia agents): \_\_\_\_\_
  2. Intravenous: \_\_\_\_\_
  3. Intramuscular: \_\_\_\_\_
  4. Combination: \_\_\_\_\_
  5. What location is the general anesthesia or deep sedation procedure performed? \_\_\_\_\_
  6. Who administers general anesthesia in your office? \_\_\_\_\_
- C. How many years have you been using conscious sedation or general anesthesia in your office? \_\_\_\_\_
- D. How many times (on the average) per week do you use conscious sedation or general anesthesia in your office? \_\_\_\_\_
- E. Please specify the types of major surgical procedures performed while treating patients under conscious sedation or general anesthesia:
- Major: \_\_\_\_\_
- Minor: \_\_\_\_\_
- F. Indicate if you have had the following training and, if so the date and period of time spent training:
- Hospital training in the use of general anesthesia: \_\_\_\_\_
- University training in general anesthesia: \_\_\_\_\_
- Hospital training in conscious sedation: \_\_\_\_\_
- University training in conscious sedation: \_\_\_\_\_
- Other type of training: \_\_\_\_\_
- G. I am certified by or a member of the following organizations that requires training in general anesthesia:
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AAOMS         | <input type="checkbox"/> ABOS          | <input type="checkbox"/> ACOMS                        |
| <input type="checkbox"/> Fellows, ADSA | <input type="checkbox"/> Members, ASDA | <input type="checkbox"/> Other, please specify: _____ |

## Procedural Questions

For **each** procedure in Section (a) below, please provide the approximate number of times you have "Performed" or "Assisted" during the past 12 months as well as how many times you anticipate doing so during the next 12 months. If you Perform or Assist in other procedures not listed below, add one in the "Remarks" section.

(a) General Procedures:	# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year
Orthodontic Full Mouth Banding	____	____	____	____
Dental Implants	____	____	____	____
Surgical Placement (Explain below)	____	____	____	____
Prosthetic or Restorative	____	____	____	____
Nerve Grafts	____	____	____	____
Parotid Gland Surgery	____	____	____	____
Orthognathic Surgery	____	____	____	____
Management of Malignant Lesions	____	____	____	____
Cleft Lip and Palate Surgery	____	____	____	____
Face Lifts	____	____	____	____
Rhinoplasty	____	____	____	____
Sleep Apnea Therapy	____	____	____	____
Intermaxillary Fixation for Obesity or Weight Control	____	____	____	____
Sinus Lifts	____	____	____	____
Root Canal Therapy	____	____	____	____
Molar Endodontics	____	____	____	____
TMJ Surgery	____	____	____	____
TMJ Arthroscopy	____	____	____	____
TMJ Reconstructive	____	____	____	____
TMJ Implants	____	____	____	____
Other (Explain below)	____	____	____	____
Other Dental Surgery (Explain type in remarks section)	____	____	____	____

**Remarks**

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**(b) Anesthesia Information:**

Do you treat patients under any of the anesthetic modalities listed below?

(a) None YES  NO

(b) Local Anesthesia YES  NO

(c) Nitrous Oxide analgesia YES  NO

(d) Oral (swallowed) conscious sedation YES  NO

(e) Parenteral conscious sedation (including intravenous or intramuscular) in a hospital, surgicenter or an office administered by you YES  NO

(g) General anesthesia – in a hospital, surgicenter or an office administered by a Dentist Anesthesiologist, M.D. Anesthesiologist or Oral Surgeon YES  NO

(e) General anesthesia – in a hospital, surgicenter or an office administered by you YES  NO

(f) How many years have you used conscious sedation in your office? \_\_\_\_\_ Years

(g) How many years have you used general anesthesia in your office? \_\_\_\_\_ Years

(h) Do you hold a current ACLS Certificate? YES  NO

(i) Are you and your staff certified in Basic Life Support (CPR)? YES  NO

(j) Are the vital signs of your patients under sedation or general anesthesia being **continuously** monitored? YES  NO

If YES, by whom?  
You  CRNA  DDS Anesthetist  Other  (Explain)

(k) Which of the following methods do you use in monitoring patients? **Please indicate the appropriate codes based on mode of anesthesia: (S) for Sedation, (G) for General Anesthesia or (B) for Both modalities:**

\_\_\_\_\_ Manual monitoring of blood pressure and heart rate  
 \_\_\_\_\_ Precordial stethoscope  
 \_\_\_\_\_ Electronic/automatic monitoring of blood pressure and heart rate  
 \_\_\_\_\_ EKG Monitor  
 \_\_\_\_\_ Pulse-oximeter  
 \_\_\_\_\_ Other (Please specify) \_\_\_\_\_

(l) Which of the following items do you have available for emergency treatment?

Crash Cart YES  NO

Ambu Bag YES  NO

Oral Airway YES  NO

Oxygen YES  NO

Endotracheal tubes/scopes YES  NO

Emergency drugs YES  NO

# DBIC

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