Pre-Sedation Check-In

Patient Name: ___________________________________

DOB: ____/____/_____

Please initial the following:

________Last Solid Food: ______AM or PM

_________Last Clear Liquids: _____AM or PM

_________For the safety of you and your child, parents are not allowed in the treatment room during Sedation.

_________You must remain in the office during your child's entire procedure. We may need to consult with you.

__________While in the office, please do not use your cell phone or any other device to video or take photographs of your child before, during, or after their procedure.

Parent/Guardian Signature ______________________________ Date

Office Use Only

___Weight:

___Height:

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