

# MEDICAL SECURITY INSURANCE COMPANY

## Conscious Sedation Questionnaire

Dentist Name: \_\_\_\_\_  
Practice Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**1. Please indicate the methods of anxiety and pain control utilized in your practice:**

- Inhalation Analgesia: Nitrous Oxide Inhalation**
- Enteral Conscious Sedation (Anxiolysis)**  
Conscious sedation that is achieved by the oral or rectal administration of a single pharmacological agent, in one of more doses, within a twenty-four hour period, including the time of treatment, possibly in combination with nitrous oxide
- Complex Enteral Conscious Sedation**  
Conscious sedation that is achieved by the oral or rectal administration of multiple pharmacological agents, in single or multiple doses, within a twenty-four hour period, including the time of treatment, possibly in combination with nitrous oxide.
- Parenteral Conscious Sedation**  
Conscious sedation achieved by the administration of pharmacological agents intravenously, intramuscularly, subcutaneously, submucosally, intranasally, or transdermally.

**2. If coverage is being requested for sedation requiring a special permit by the NC State Board of Dental Examiners, the following documents are required and must be attached in order for further consideration:**

- A copy of the completed Application for General Anesthesia or Sedation Permit
- A copy of the permit, temporary or permanent, issued by the NC State Board of Dental Examiners.

**3. Indicate the Oral Medications utilized for Sedation:**

<input type="checkbox"/> Valium (Diazepam)	<input type="checkbox"/> Serax (Oxazepam)
<input type="checkbox"/> Xanax (Alprazolam)	<input type="checkbox"/> Phenergan (Promethizazine)
<input type="checkbox"/> Ativan (Lorazepam)	<input type="checkbox"/> Buspar (Buspirone)
<input type="checkbox"/> Atarax (Hydroxyzine)	<input type="checkbox"/> Nembutal (Pentobarbital)
<input type="checkbox"/> Sonata (Zaleplon)	<input type="checkbox"/> Luminal (Phenobarbital)
<input type="checkbox"/> Ambien (Zolpidem)	<input type="checkbox"/> Noctec (Chloral Hydrate)
<input type="checkbox"/> Halcion (Triazolam)	<input type="checkbox"/> Zopiclone (Imovane)
<input type="checkbox"/> Versed (Midazolam)	<input type="checkbox"/> Ketamine
<input type="checkbox"/> ProSom (Estazolam)	<input type="checkbox"/> Others (please list): _____

**4. Do you redose?**

- Yes  No If yes, how long is the interval for each drug before it is redosed? \_\_\_\_\_

**5. Please advise where the drug is administered:**

- at home  in-office  combination

**6. Do you require that the patient sign a form stating that an adult driver must be present to take them home and monitor them after sedation and procedure?**

- Yes  No If no, please explain:
- \_\_\_\_\_
- \_\_\_\_\_

7. Indicate the percentage (%) of your total patients that are administered Oral Sedation.  
\_\_\_\_\_ % Children \_\_\_\_\_ % Elderly (> 65 years old) \_\_\_\_\_ % Medically Compromised

8. Do you administer less than normal doses to the elderly and medically compromised?  
 Yes  No If no, please explain:

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9. Do you administer Enteral Conscious Sedation to children under 13?  Yes  No  
If yes, have you completed the 6 hour minimum course in Pediatric Conscious Sedation as required by Section .0401 (d) (2) in addition to the 18 hour course required for Enteral Conscious Sedation?  Yes  No If no, please explain:

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11. Do you have a trained staff member continuously in the treatment room (chairside), monitoring the patient from time of drug administration until the patient is dismissed?  
 Yes  No If no, please explain:

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12. Do you have written policies and protocol for the discharge of the patient and follow-up?  Yes  No If no, please explain: \_\_\_\_\_

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13. Are patients given written discharge instructions?  Yes  No If no, please explain:

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14. Indicate where you monitor the patient post treatment.

Recovery Area  Treatment Room

15. Are you and all members of your clinical staff BLS (Basic Life Support) certified with recertification every two years?

Yes  No If no, please explain:

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16. Consents and Instructions: Indicate the following procedures that you or your staff perform in the office, by checking the appropriate box.

- Obtain appropriate Consent Forms for the procedures, as well as the sedation
- Record and document all treatment and reactions
- Perform proper Pre and Post treatment instructions

**IMPORTANT:** This Sedation Questionnaire must be signed by the insured. The above statements are an accurate and honest representation of my current practice.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date of Signature)