

# INFORMED CONSENT FOR SEDATION

## A. IDENTIFICATION

I, \_\_\_\_\_ willingly agree to the following procedure:  
*(Print your full name)*

## B. STATEMENT OF REQUEST

**Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.** I hereby authorize Dr. \_\_\_\_\_ and staff to perform the following procedures: and to administer the anesthesia I have chosen, which is:

- Local Anesthesia
- Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
- Local Anesthesia with Oral Premedication & Nitrous Oxide/Oxygen Analgesia
- Local Anesthesia with Intravenous Sedation
- General Anesthesia

Other treatment options: \_\_\_\_\_

\_\_\_\_\_ 1.) **ANESTHETIC RISKS INCLUDE:** discomfort, swelling, bruising, infection, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability, and may require special care. Nausea and vomiting, although uncommon, may be an unfortunate side effect of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the rare risks of heart irregularities, heart attack, stroke, brain damage or death.

- \_\_\_\_\_ 2.) **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED:**
- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are recovered sufficiently to care for yourself. This may be up to 24 hours.
  - B. During your recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents.
  - C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
  - D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or medications provided by this office, using only a small sip of water.

\_\_\_\_\_ 3. I understand that no guarantee can be promised, and I give my free voluntary consent for treatment. I realize that my doctor may discover conditions requiring different surgery from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgment.

\_\_\_\_\_ 4.) I have been fully advised of and completely understand the alternatives to sedation and accept the potential risks and dangers. I acknowledge the receipt of both preoperative and postoperative instructions. I have had the opportunity to ask questions about my sedation and I am satisfied with the information provided to me.

### INFORMATION FOR FEMALE PATIENTS

\_\_\_\_\_ 1.) I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initial additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

\_\_\_\_\_ 2.) I am not pregnant, and I am not trying to get pregnant at this time. I am not nursing at this time. I understand that sedative medications and other drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion.

## C. SIGNATURES

**1. COUNSELING DENTIST/PROFESSIONAL:** I have counseled this patient as to the nature of the proposed procedure(s), attendant risk involved, and expected results, as described above.

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<b>Signature of Counseling Dentist/Professional</b>	<b>Date and Time</b>
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**2. PATIENT:** My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read and write English.

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<b>Signature of Patient or Legal Guardian</b>	<b>Date and Time</b>
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<b>Signature of Witness</b>	<b>Date and Time</b>
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