Croasdaile
DENTAL ARTS
Your Smile. Our Passion.

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CONSENT FOR ORAL/IV SEDATION

ALTERNATIVE TYPES OF ANESTHESIA: I have been informed that my treatment can be performed with a variety of types of anesthesia: (1) local anesthesia as normally used for minor dental treatment; (2) local anesthesia supplemented with orally administered conscious sedation; and (3) local anesthesia supplemented with IV administered conscious sedation.

I have been made aware that the risks with each type of anesthesia vary, with local anesthesia generally considered to have the least risk and general anesthesia having the greatest risk. I have been advised that if I am significantly subject to fear, anxiety or emotional stress related to dental procedures, or if a long or stressful procedure is to be undertaken, or if certain medical or physical conditions exist, this risk sequence can change, and conscious sedation, properly administered, might be beneficial relative to other anesthetics alternatives.

I understand that, based on Dr. ___________'s judgment, one or more of the choices for anesthesia may not be desirable in every case.

THE PROCESS OF ORALLY ADMINISTERED CONSCIOUS SEDATION: I have been informed that the objective of conscious sedation is to lessen the significant and undesirable side effects of long and stressful dental procedures by chemically reducing the fear, apprehension, emotional and physical stresses sometimes present.

This is accomplished by the oral administration of small doses of various medications such that they produce a state of relaxation, reduced perception of pain and a degree of drowsiness, but that I will not be put to sleep as with a general anesthetic. In addition, local anesthetics will be administered in my mouth to numb the areas to be operated so as to control pain.

POSSIBLE RISKS AND SIDE EFFECTS: I have been informed and understand that occasionally there are complications associated with oral sedation including but not limited to: nausea, hallucinations, vomiting, allergic reaction, and in extremely rare instance, brain damage or death.

PATIENT COMPLIANCE: I agree to the following:

- I will refrain from eating for 6 hours prior to my dental appointment
- I will refrain from consuming any alcoholic beverages for 24 hours before and 24 hours following this procedure
- I have disclosed to the doctor any and all drugs and medications I am currently taking
- I have disclosed any abnormalities in my current physical status or past medical history including any history of drug or alcohol abuse or any abnormal reactions to any drugs/medications which I have taken
- I will arrange for a responsible adult to drive me to the office and home, and be with me until the effects of the sedation have worn off.
- I understand that I must advise the designated driver to accompany inside and remain with me until I am called back to the treatment room.
- I understand that I must advise the designated that if they wish to leave to run a short errand while I am undergoing treatment that they must notify your front office staff and provide a contact number should they need to be reached.

- I will refrain from driving a motor vehicle, operating dangerous machinery or returning to work for the remainder of the day while under sedation.
- No Grapefruit juice or Grapefruit product for 7 days before appointment

PATIENT COMFORT:
- We suggest that you wear comfortable clothing (ie: lightweight jogging suit, etc).
- We are not responsible for personal items and request that you not wear any jewelry on the day of your appointment.
- Do not bring your purse or cell phone back with you in the treatment room. Please leave it with your designated driver.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to oral conscious sedation as presented to me during my consultation and treatment plan presentation by the doctor or as described in this document.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration,

I give my consent for the performance of any and all procedures related to my treatment noted below as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

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______________________________	______________________________
Patient's Signature	Date
______________________________	______________________________
Patient's Guardian Signature (note relationship to patient)	
______________________________	______________________________
Witness	Date

Updated 05/2017