

Consent for Oral Sedation/Anesthesia

Patient name _____ Date _____

Procedure _____

I have requested an oral sedative: Valium, Halcion, Ativan, (other) _____ with a dosage of _____ to help relieve anxiety and/or apprehension. I understand the sedative may cause dizziness, drowsiness, time constriction, motor incoordination and fatigue. I understand that I must have a responsible adult transport me to the office and home afterward. I understand that I will be under the influence of the sedative for 8 to 10 hours and agree to stay at home under the supervision of an adult, and will not attempt to drive, supervise or care for children, or perform anything that requires coordination or personal judgment. I understand that I can NOT have any alcohol, tranquilizers or other sedatives on the day of the treatment — either before or after treatment.

Anesthesia includes:

Local anesthesia: Novocain, Lidocaine, etc., to block pain pathways in a localized area (by injection)

Local intravenous sedation or general anesthesia: alters your awareness of the procedure by producing sedative/amnesic effects or sleep

I understand there are risks involved with both anesthesia and oral sedation that can include but are not limited to:

- Nausea and vomiting
- Temporary or permanent partial numbness to face or tongue
- Unexpected allergic reaction
- Pain, swelling, bruising or inflammation to the area of injection
- Prolonged disorientation, confusion or drowsiness after treatment
- Respiratory or cardiovascular responses that can lead to stroke, heart attack or death
- Falls caused by instability post-ingestion.

I also understand and agree that prior to any anesthesia, I will not ingest any fluids or solids by mouth for six (6) hours prior to the dental procedure, as this could be life-threatening.

I understand that I must have a responsible adult transport me to the office and home afterward. I understand that I will be under the influence of the sedative for 8 to 10 hours and agree to stay at home under the supervision of an adult, and will not attempt to drive, supervise or care for children, or perform anything that requires coordination or personal judgment.

I also agree that I have provided a complete and truthful medical history that includes all medications, drug use, pregnancy, etc.

We invite your questions concerning this or related procedures and their risks. By signing below you acknowledge that you have read this document, understand the information presented, understand that you could see a specialist but are choosing care from the treating dentist, and have had all your questions answered satisfactorily.

Additional comments _____

_____ Date _____
Patient signature/legally authorized representative

_____ Relationship _____
Printed name if signed on behalf of the patient

_____ Date _____
Doctor signature