ADVANCED
Implants & Periodontics

CONSENT FOR SEDATION DENTISTRY

The following is provided to inform the patient or parent/ guardian of a patient under 18 years of age of the choices and risks involved with having treatment under conscious sedation. You will not be asleep, although you will be in a relaxed state. You will still be able to communicate with the dentist during treatment. Even though sedation dentistry is safe and effective, you should be aware of the following considerations:

___ I understand that the purpose of conscious sedation, either using nitrous, oral or IV methods is to placed me in a relaxed state during treatment. I understand the effects of medications are not guaranteed and may vary amongst individuals. I understand that conscious sedation is not required.

___ I am not currently being treated for depression, myasthenia gravis, wide-angle glaucoma, closed angle glaucoma, severe chronic obstructed lung disease (COPD), sleep apnea, low amount of albumin proteins in blood, cystic fibrosis nor do I have lung, liver and kidney dysfunction.

___ I am not taking the following medications: Serzone (nefazodone), Tagamet (cimetidine), Levodopa, antihistamines, Cardizem (diltiazem), erythromycin, antimycotics (antifungal drugs), bleomycin sulfate (anti-neoplastic therapy), anti-HIV drugs, recreational drugs or alcohol.

___ I have not recently received eye surgery (that involve introducing an intraocular gas), or ear surgery (tympanic membrane graft or have blocked Eustachian tubes).

___ I do not have a history of hypersensitivity to benzodiazepines (Valium, Ativan, Versed, etc).

___ Side effects/ risks of conscious sedation include but are not limited to pain, nausea, vomiting, headache, amnesia, visual disturbances, allergic reaction to medication, infection from the IV line, and respiratory depression that can be fatal. The most frequent side effects are drowsiness, nausea, and vomiting.

___ I understand that the medications and drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing my health care provider of a suspected or confirmed pregnancy. For the same reason I understand that I must inform if I am a nursing mother.

___ I understand that during the procedure, a change in treatment may be required. I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I authorize the doctor to discuss my care and instructions with my designated escort.

___ I understand that sedation is a drug induced state of reduced awareness and decreased ability to respond. I will have a driver before and after treatment. I will have a care taker with me for a minimum of four to six (4-6) hours after treatment.

___ Because multiple medications may cause drowsiness, I have been advised not to operate any vehicle or make any important decisions for at least 24 hours after conscious sedation.

___ **I understand that my driver will need to remain in the office for the entirety of my procedure.**

___ Alternatives to conscious sedation include no sedation or another form of anesthesia.

___ I understand English or have had someone translate the meaning of this document to me. I am not under the influence of alcohol or other mind altering substances. I have had an opportunity to ask my questions and discuss my concerns with my doctor to my satisfaction

I hereby authorize and request conscious sedation. I have been fully advised and accept the possible risks and dangers of sedation. I also completely understand the alternatives to sedation. I acknowledge the receipt of and understand the conscious sedation instructions.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Responsible Party Name (please print): _____ Date: _____

Responsible Party Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Patient Signature: _____ Date: _____

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