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Consent For Conscious Sedation

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Diagnosis:

I have been informed that my treatment can be performed with a variety of types of anesthesia. These include local anesthesia as normally used for routine dental treatment, local anesthesia supplemented with oral or IV conscious sedation, and general anesthesia in the hospital or out-patient surgical center. My periodontist has recommended oral or IV conscious sedation in addition to other possible forms of anesthetic because a somewhat long and stressful procedure is to be undertaken, certain medical or physical conditions of mine may so indicate, or I am subject to significant anxiety and emotional stress related to dental procedures.

Recommended Treatment:

I understand that in conscious sedation, small doses of various medications will be administered to produce a state of relaxation, reduced perception of pain, and drowsiness. However, I will not be put to sleep as with a general anesthetic. In addition, local anesthetics will be administered to numb areas of my mouth that will be operated on.

I understand that the drugs to be used may include the following:

Halcion, Valium, Nitrous Oxide

I recognize that I must do several things in connection with IV or oral conscious sedation:

Specifically I must refrain from eating (6) six hours before my dental appointment. I must not drink any alcoholic beverages or take certain sedatives for (12) twelve hours before and (24) twenty four hours after the procedure. Further, I will arrange for a responsible adult to drive me home and stay with me until the effects of the sedation have worn off. I will not drive a motor vehicle or operate dangerous machinery on the day I receive the sedation.

Expected Benefits:

The purpose of conscious sedation is to lessen the significant and undesirable effects of long or stressful dental procedures by chemically reducing the fear, apprehension, and stresses sometimes associated with these procedures.

Principal Risks and Complications:

I understand that occasionally complications may be associated with oral or IV conscious sedation. These include pain, facial swelling, bruising, inflammation of a vein (phlebitis), infection, bleeding, discoloration, nausea, vomiting, and allergic reaction. I further understand that, in extremely rare cases, damage to the brain or other organ supplied by an artery, and even death, can occur.

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To help minimize risks and complications, I have disclosed to my periodontist any and all drugs and medications that I am taking. I have also disclosed any abnormalities in my current physical status or past medical history. This includes any history of drug or alcohol abuse and any reactions to medications or anesthetics.

Alternatives:

Alternative options to conscious sedation include local anesthesia or general anesthesia as an in-patient or out-patient. Local anesthesia may not adequately dispel my anxiety, fear, or stress. If certain medical conditions are present, it may present a greater risk. There may be less control of proper dosage with oral sedation than with IV sedation. General anesthesia will cause me to lose consciousness and generally involves greater risk than oral or IV conscious sedation.

Necessary Follow-up Care and Self-Care:

I understand that I must refrain from drinking alcoholic beverages and taking certain medications for (24) twenty four hours following the administration of oral or IV conscious sedation. I also understand that a responsible should drive me home and remain with me until the effects of the sedation have worn off and that I should not drive or operate dangerous machinery for the remainder of the day which I have received sedation

No Warranty or Guarantee:

I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful. I recognize that, as noted above, there are risks and complications involved with the administration of IV or oral conscious sedation.

Publication of Records:

I authorize photos, slides, or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public without my permission.

Patient Consent

I have been fully informed of the nature of IV and oral conscious sedation, the procedure to be utilized, the risks and benefits of conscious sedation, the alternatives available, and the necessity for follow-up. I have had an opportunity to ask any questions I may have in connection with the procedure and to discuss any concerns with Dr. Williams. After thorough deliberation, I hereby consent to the performance of oral or IV conscious sedation as presented to me during consultation and in th treatment plan as described in this document.

I Certify That I Have Read And Fully Understand This Document

Response Date: _____