



Consent For Conscious Sedation

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 minor dental treatment, local anesthesia supplemented with oral medication, and local anesthesia with conscious sedation. My periodontist has recommended conscious sedation in addition to other possible forms of anesthetic because a 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 the areas of my mouth to be treated and thus further control pain. I understand that the drugs to be used may include:
_____, _____, and _____.

I recognize that I must do several things in connection with conscious sedation. Specifically, I must refrain from eating for four (4) hours before my dental appointment. I must not drink any alcoholic beverage or take certain medications for twelve (12) hours before and twenty-four (24) 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 that I receive the sedation.

PRINCIPAL RISKS AND COMPLICATIONS I understand that occasionally complications may be associated with conscious sedation. These include pain, inflammation of a vein (phlebitis), infection, bleeding, discoloration, nausea, vomiting, and allergic reaction. I further understand that in extremely rare instances, damage to the brain or other organs supplied by an artery, and even death, can occur.

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.

NECESSARY FOLLOW-UP CARE AND SELF-CARE I understand that I must refrain from drinking alcoholic beverages and taking certain medications for a twenty-four (24) hour period following the administration of conscious sedation. I also understand that a responsible adult 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 on which I receive 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 potential complications in the administration of conscious sedation.

I have had an opportunity to ask any questions I may have in connection with the procedure and to discuss my concerns with my periodontist. I certify that I have read and fully understand this document.

Patient's Name (print) _____ Patient Signature _____

Date _____ Witness _____ Date _____