REQUEST FOR ANESTHESIA AND SEDATION

It is our moral and legal obligation to give you the information necessary to make an educated decision in requesting treatment. The benefits of therapy are usually greater than the risk, but just as there are risks involved with driving a car, there are events that can occur with any type of treatment. These are being explained to inform and educate you...not to alarm you. Eliminating surprises will make your care go more smoothly. As with any dental procedure you must advise us of your medical status including a complete disclosure of all medication and/or drugs that you are currently taking with special notice to us if you are pregnant, have glaucoma, suffer from sleep apnea, or use any type of sleep apnea device.

_____initial

Medical History _____

_____

Current Medication List as of _____ (date)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Emergency Contact: _____Phone: _____

Common occurrences

1. Chapping of the lips caused by stretching the corners of the mouth during surgery.
2. Stiffness of the jaws and restricted mouth opening from several days to several weeks depending on the extent of the treatment.
3. Possible temporary amnesia.
4. Temporary side effects may include but are not limited to ataxia, abnormal gait, confusion and lethargy.

_____ initial

Rare occurrences

Can include any event that might be remotely possible but unlikely to occur. People rarely plan their lives around these, but are still aware that they can occur. These include: allergic reaction to drugs which range from hives to heart failure. Many drug reactions are side effects and treated as such.

The office staff has had training in managing these potential problems.

_____initial

Medication, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and co-ordination, which can be increased by the use of alcohol or other drugs. Do not operate any vehicle, automobile or hazardous device for 18 hours after taking such medication and /or drugs. Your judgment and work performance can be altered by pain medication or the sedative agents and you should plan accordingly.

_____initial

Do not eat for at least four hours before the appointment. There is no safety hazard associated with eating within that time period, but the body absorbs the medication better on an empty stomach.

_____initial

Your signature below certifies....

- Your permission to discuss your dental and sedation treatment with your accompanying adult, spouse, partner, family member, friend or physician if deemed reasonably necessary for your immediate dental health and safety.
  _____initial
- Your agreement to the administration of anesthesia, nitrous oxide/oxygen and /or oral sedation as discussed with Dr. Wilson or Dr. Fizer.
  _____ initial
- Your authorization for Dr. Wilson or Dr. Fizer to use their best judgment in managing unforeseen conditions which might unexpectedly arise during the course of the procedure.
  _____ initial
- That you are both mentally and physically competent to give this consent.
  _____initial

_____ _____
Patient, Parent or Guardian Date

_____ _____
Witness Date

_____ _____
Doctor Date