THE DENTAL
ANESTHESIA CENTER

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Patient:

CONSENT FORM: Sedation, Anesthesia, and/or Oral Surgery, Dental Care

Dental and/or oral surgical procedures selected by me and planned to be done by a qualified member of The Dental Anesthesia Center have been explained to me. Some possible complications of the use of medications and treatment including intravenous sedation and general anesthesia have also been explained to me. This is my consent to that planned and proposed oral/dental care.

I agree to the use of local anesthesia, oral, inhalation, or intravenous sedation and general anesthesia in the office or hospital, and other medications deemed necessary for my care.

Understanding the unforeseen conditions which may develop, I further consent to any additional treatment or alteration of the planned treatment that a qualified member of The Dental Anesthesia Center may deem necessary.

I have been informed and understand that, there are complications of dental and/or oral surgical care, medications, local anesthesia, intravenous sedation and general anesthesia. Complications are rare and can range from minor up to and including death. Although not usual, some of the more common complications reported include: nausea and vomiting, spasm of the vocal chord (laryngospasm), spasm of the lungs (bronchospams), inflammation of the vein (phlebitis), drowsiness, pain, infection, swelling, bleeding, bruising, discoloration, temporary or permanent numbness and tingling of the lip, tongue, chin, gums, cheek, or teeth.

The possibility of injury to or stiffness of the neck and facial muscles and changes in the occlusion or in the temporomandibular joint has been explained. It has been discussed with me the possibility of; injury to the adjacent teeth, restorations in other teeth or tissues, loss of tooth vitality due to dental decay or treatment, referred pain to the ear, neck, or head; nausea, vomiting, allergic reactions, bone fractures, delayed healing, sinus complications which may include a naso-antral fistula or opening into the sinus from the mouth may occur with removal or treatment of upper teeth.

Prescription medications, other medications, anesthetics, and intravenous medications may cause prolonged drowsiness, lack of awareness and coordination. The use of alcohol or other medications can increase these effects. Thus, I have been advised NOT to consume, take or use ANY alcohol and/or other medications not prescribed by qualified members of The Dental Anesthesia Center or by my physician 12 hours prior to and 24 hours after my dental appointment. I have been advised NOT to operate any vehicle or hazardous devices or work while taking such medications, or to make serious decisions or sign legal papers until fully recovered from the effects of such medications, sedative drugs, or anesthetics that may have been given to me by qualified members of The Dental Anesthesia Center or the anesthesiologist at the hospital where treatment was rendered.

Risks and benefits of treatment have been discussed and thoroughly explained to me.

This consent will be considered to be in force for all times that I seek dental care by qualified members of The Dental Anesthesia Center. I will inform a member of The Dental Anesthesia Center of any changes in my health or otherwise which could alter general or specific areas of this consent.

I acknowledge the receipt of and understand the preoperative and the post-operative instructions. It has been explained to me and I understand that there is no warranty or guarantee as to any result and/or cure. I understand that I can ask for more comprehensive recital of additional possible risks.

I understand and acknowledge that I, as the patient (or I as the parent or guardian), will be financially responsible for the services provided, regardless of insurance coverage.

PATIENT ______________________________ DATE ______________
(OR LEGAL GUARDIAN)
WITNESS ______________________________ DATE ______________

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WITNESS ______________________________ DATE ______________

Pregnancy Advisory

I,______________________________, have been advised that I am going to have an intravenous anesthesia.

I have been advised that if I am pregnant, the intravenous anesthesia could have serious effects on the fetus, including, but not limited to, birth defects, miscarriage and death.

______ I may be pregnant and decline anesthesia at this time.

______ I am unsure of my pregnance status and will take a pregnancy test.

______ I have no reason to believe that I am pregnant and authorize a qualified member of The Dental Anesthesia Center to proceed with the intravenous sedation.

Signed: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________

Signed: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________