INFORMED CONSENT

THE DENTAL
ANESTHESIA CENTER

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Patient:

INFORMED CONSENT for 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 treatment, 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
NAME
sedation, general anesthesia or any other medications deemed necessary for my care.

Understanding that unforeseen conditions may develop, I further consent to any additional treatment or alteration of the planned or unplanned treatment that a qualified member of The Dental Anesthesia Center may deem medically necessary. Personnel of The Dental Anesthesia Center will attempt to contact my medical power of attorney, or legal guardian. However, if they are unable to be reached, I give consent to doctors at The Dental Anesthesia Center to provide any urgent care that may lead to infection or pain before the next scheduled appointment.

I have been informed and understand that there is a potential for complications during dental care, oral surgery, consumption of 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 cord (laryngospasm), 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, facial muscles and Temporomandibular Joint (TMJ) has been explained. Changes in the occlusion may also contribute to TMJ, teeth or myofascial pain. The possibility of injury to the adjacent teeth, restorations, tissue, loss of tooth vitality due to dental decay or treatment, referred pain to the ear, neck, or head, nausea, vomiting, allergic reactions, bone fractures, and delayed wound healing have been discussed with me. Sinus complications which may include an oral-antral fistula (an opening from the mouth into the sinus) may occur with removal or treatment of upper teeth.

Prescription medications, OTC, intravenous, and anesthetic medications may cause prolonged drowsiness, and lack of awareness and coordination. The use of alcohol or other medications can increase these effects. Thus, I have been advised NOT to consume ANY alcohol or other medications not prescribed by or approved by qualified members of The Dental Anesthesia Center 12 hours prior to and 24 hours after my dental appointment.

I have been advised NOT to make serious decisions, sign legal papers, operate any vehicle, hazardous device or machine for at least 24 hours after the dental procedure. It is my responsibility to secure transportation to and from The Dental Anesthesia Center on the day of my anesthesia appointment. I must be accompanied by a family member, acquaintance or someone who will take responsibility for my actions while I am under the influence of sedative medications (this does NOT include cab drivers, Uber or Lyft drivers).

I acknowledge the receipt of and understand the pre-operative 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.

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

This document will serve as my consent for all appointments 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 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.

Pregnancy Advisory

I,_____, have been advised that I am going to have sedation or general anesthesia.

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

_____ I may be pregnant and decline sedation or general anesthesia at this time.

_____ I am unsure of my pregnancy 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 sedation or general anesthesia.

FOR APPT _____ PATIENT _____ TODAY'S DATE _____
(OR LEGAL GUARDIAN)

WITNESS _____ TODAY'S DATE _____
(OFFICE PERSONNEL)