

## CONSENT FOR CONSCIOUS SEDATION (ORAL MEDICATION AND/OR NITROUS OXIDE AND OXYGEN)

**Patient's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

I hereby authorize Dr.(s) \_\_\_\_\_ to perform necessary dental treatment on my child/legal ward utilizing conscious sedation techniques including mild oral sedatives and/or nitrous oxide and oxygen administration (laughing gas) in addition to the dental anesthetic(s). I understand that my child is either unable to be treated in a cooperative patient – doctor setting using usual and customary dental techniques or the procedure requires the need of conscious sedation. The purpose and nature of the need for conscious sedation has been fully explained to me.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to the sedative drug or the local anesthetic drug, or atypical psychological response that may even cause necessary hospitalization, further surgical procedures, disability, and system impairment. Serious adverse effects are rare; however, cases of permanent or temporary nerve damage, brain damage or death have occurred. In case of an emergency I further authorize Dr.(s) \_\_\_\_\_ to perform treatment as may be advisable to preserve the health and life of my child or legal ward.

I understand that sedation may prove partially or completely ineffective in managing my child or legal ward. In such an instance the planned treatment may not be possible or may require several appointments using these conscious sedation techniques to complete the necessary dental work or an alternative treatment may be instituted or the patient may need to be referred for treatment to a hospital facility.

I have been provided with pre-operative and post-operative instructions and with an explanation of alternatives to treatment and understand the risks of not being treated for the dental condition.

Dental insurance plan policies vary and often do not cover sedation. I understand that nitrous /O2 inhalation and/or oral sedation may not be covered by my dental insurance, and I will be financially responsible for the sedation fee.

This consent will remain active and covers all planned sedation sessions under the treatment plan. I understand that I may withdraw this consent if and when I choose to do so.

I have carefully read the above and in addition have had all my questions in regard to sedation to be administered, the outlined risks, and side effects answered. I also acknowledge the receipt of and understand the pre-operative and post-operative instructions.

I do give my free and voluntary informed consent to the same.

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_