

ANESTHESIA INFORMED CONSENT

Patient's Name

Date of Birth

This form and your discussion with your doctor are intended to help you make informed decisions about the anesthesia options for your treatment. Your doctor is available to answer any questions you may have regarding anesthesia and provide additional information before you decide whether to sign this document and proceed with the procedure.

1. I have elected to proceed with the anesthesia(s) indicated below.

- _____ Local Anesthesia
- _____ Nitrous Oxide (Laughing Gas)
- _____ Mild Sedation
- _____ Moderate Sedation
- _____ Deep Sedation (General Anesthesia)

I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:

- Nerve injury, which may occur from the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent and/or require additional treatment;
- Allergic or adverse reactions to medications or materials;
- Pain, swelling, redness, irritation, numbness and/or bruising in the area where the IV needle is placed. Usually the numbness or pain goes away, but in some cases, it may be permanent;
- Nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness. Some patients may have an awareness of some or all events of the surgical procedure after it is completed;
- Heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest), or death;
- Sore throat or hoarseness if a breathing tube is used.

2. I have been informed of and understand that follow up visits or care, additional evaluation, treatment or surgery, and/or hospitalization may be needed.

3. Patient's Responsibilities

I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I understand and accept the use of tobacco and alcohol is detrimental to the success of my treatment and will comply with my doctor's instructions.

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I understand and agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.

If I have elected Mild, Moderate, or Deep Sedation (General Anesthesia), I have not had anything to eat or drink for at least six (6) hours prior to my procedure. I understand that doing otherwise may be life-threatening. As instructed, I have taken my regular medications (blood pressure medications, antibiotics, etc.) and/or any medicine given to me by my doctor using only small sips of water. I am accompanied by a responsible adult to drive me to and from the doctor's office and he/she will stay with me after the procedure until I am recovered sufficiently to care for myself. I understand the drugs given to me for this procedure may not wear off for 24 hours. During my recovery from anesthesia, I agree not to drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

I had sufficient time to read this document, understand the above statements, and have had a chance to get all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of my anesthetic and agree to proceed.

If I am sedated or under general anesthesia during the procedure, I further authorize the doctor to modify the procedure if, in his professional judgment, it is in my best interest.

Patient or Legal Representative Signature

Date

Print Patient or Legal Representative Name/Relationship

Witness to Patient Signature

Date