MODERN DENTISTRY

Informed Consent for Anxiolysis or Conscious Sedation

_____ I give my consent to the use of any local anesthetics, nitrous oxide, any oral and intravenous sedative, analgesic (pain reducing), and/or other medications that the dentist may deem necessary or advisable so as to enable the providers of service to render dental treatment as indicated on my examination chart, which I acknowledge, by my signature below, has been previously explained to me.

_____ I have been informed and understand that occasionally there are complications involved in this type of treatment and/or the use of these types of drugs or anesthetic agents; including but not limited to: temporary or permanent numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, stroke, or heart attack. I further understand and accept that complications may require hospitalization and may even result in death.

_____ The undersigned doctor has discussed with me, to my satisfaction, these complications. I acknowledge the receipt of and understand the pre-operative and post-operative instructions. The treatment and sedation and/or anesthesia procedures have been explained to me, to my satisfaction; along with possible alternative methods and their advantages and disadvantages, risks, consequences and probable effectiveness of each, as well as, the prognosis if no treatment is provided. I understand that the use of restraints may be necessary during dental treatment with conscious sedation, as a safety measure. I agree to the use of restraints if deemed necessary by the treating doctor.

_____ I understand that any proposed treatment I will be having while under the influence of anxiolytic or sedative drugs will not allow me to give full consent for changes that may be required to keep me out of pain. For this reason, I give permission for the doctor to remove any hopeless teeth, including those that have vertical fractures, internal or external resorption, excessive mobility, or insufficient tooth structure to restore. Furthermore, in the event a tooth if found to require root canal therapy, I give permission for the doctor to remove the pulp of the tooth in order for me to decide at a later date, whether or not the tooth should ultimately be saved. Beyond these circumstances, I give the doctor permission to do whatever is necessary to minimize postoperative pain or damage to my teeth and mouth, within the goals of my overall treatment plan, if available.

I acknowledge that prior to my execution of this consent, I have read this consent and understand, to my satisfaction, the procedure to be performed and accept the possible risks.

_____	_____	_____
Patient, Parent, or Guardian Printed	Patient, Parent, or Guardian Signature	Date
_____	_____	_____
Witness	Doctor	Date