Patient: ______________________________

Informed Consent for Intravenous Sedation

To be completed by patient. If patient is under 18, parent or guardian must sign.

The purpose of this document is to provide an opportunity for patients to understand and give permission for conscious sedation when provided alongside dental treatment. Each item should be **initialed by the patient or parent/guardian** once the patient or parent/guardian has had the opportunity for discussion and questions.

______1. I understand that the purpose of conscious sedation is to make the procedure more comfortable. Conscious sedation is not required to provide the necessary care. I understand that conscious sedation has limitations and risks and that absolute success cannot be guaranteed.

______2. I understand that conscious sedation is a drug-induced state of reduced awareness and decreased ability to respond. Conscious sedation is not sleep. I will be able to respond during the procedure. My ability to respond will return to normal when the effects of the sedation wear off. I understand that with IV Sedation I may have no memory of the procedure afterwards.

______3. I understand that my conscious sedation will be achieved by **Intravenous Sedation**.

______4. I understand that the alternatives to Conscious Sedation include:

No Sedation General Anesthetic

______5. I understand that there are **risks, limitations, and complications** to all procedures. For Conscious Sedation these include, but are not limited to: discomfort, swelling, bruising, infection, allergic reactions, and nausea. There may be episodes of enhanced anxiety or panic with Nitrous Oxide sedation. There may be inadequate sedation with the Oral route, which may require the patient to undergo the procedure without full sedation or delay the procedure for another time. There may be inflammation at the site of the IV, which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of sedation. **Intravenous conscious sedation is a serious medical procedure and, although considered safe, carries with it the risks and complications of heart irregularities, heart attack, stroke, brain damage, and death.**

______6. If, during the procedure, a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem, in their professional judgment, to be necessary. I understand that I have the right to designate the individual who will make such a decision.

______7. I understand that under conscious sedation medical emergencies may arise. I authorize the doctor and the operative team to administer any medications deemed necessary to aid in the medical emergency. I also authorize for any adjunctive measures needed to help with the medical emergencies as well.

______8. I have had the opportunity to discuss conscious sedation and to have my questions answered by qualified personnel including the doctor. I also understand that I must follow all of the recommended treatments and instructions of my doctor.

______9. I understand that I must notify the doctor if I am pregnant, or if I am lactating. I must notify the doctor if I have sensitivity to any medication, of my present mental and physical condition, if I have recently consumed alcohol or recreational drugs, and if I am presently on psychiatric mood altering drugs or other medications.

______10. I will not be able to drive or operate any machinery while taking oral sedatives or IV sedatives for 24 hours after my procedure. I understand I will need to have arrangements for someone to drive me to and from my dental appointment while taking oral and/or IV sedatives.

I understand that my appointment will be cancelled by the doctor if the pre-operative instructions have not been followed and that a cancellation fee of $ 280.00 will be charged. I also understand that if I cancel with less than two (2) weeks notice, (except in emergency) there will be a **cancellation fee charged based on the amount of time scheduled for my procedure. A charge of** $280.00 will be charged for a one hour appointment, $495 for 2 hours, $700 for 3 hours and $900 for a 4 hour appointment. A deposit will be required equal to the cancellation fee for the amount of time booked.

I hereby acknowledge that I read and understand English.

I hereby consent to the use of Conscious Sedation in conjunction with my dental care.

Patient or Parent/Guardian Signature: ____________________________

Date: __________________

Doctor Signature: ____

Date: __________________