

INFORMATIONAL INFORMED CONSENT

I.V. SEDATION/ANESTHESIA

I UNDERSTAND that undergoing ANESTHESIA/I.V. SEDATION includes possible inherent risks such as, but not limited to the following:

1. **COMPLICATIONS OF THE DRUGS AND ANESTHESIA**, which include but are not limited to: tenderness, bruising, nausea, vomiting, swelling, bleeding, infection, numbness, allergic reaction, stroke, and heart attack. Some of these complications, although rare, may require hospitalization and may even result in death.
2. **BRUISING OR TENDERNESS OF THE I.V. INDUCTION SITE** may occur. Some sedative agents may cause a burning or itching sensation in the wrist or arm during induction. Edema may be caused when excess I.V. fluid enters surrounding tissues and may take several days to resolve. Sometimes phlebitis (inflammation of the venipuncture site) may require additional treatment. Tenderness/edema can be treated with warm moist heat applied to the site.
3. **NEED FOR LIMITATION OF FOOD OR DRINK.** I understand that the patient must refrain from any food or drink after midnight prior to a morning appointment. Prior to an afternoon appointment the patient is limited to a light breakfast no later than six hours before treatment time and clear liquids up to three hours before treatment. Further instructions may be given by the dentist or anesthetist or anesthesiologist depending on the procedures to be performed and other factors.
4. **CHANGES IN HEALTH ARE IMPORTANT**, including fevers or "common colds." I am expected to convey this information to the dentist prior to a planned appointment when sedation/anesthesia are involved.
5. **A RESPONSIBLE ADULT MUST ACCOMPANY THE PATIENT AT THE TIME OF DISCHARGE**, and I understand that the patient must not drive a vehicle or take a bus or taxi after undergoing I.V. sedation/anesthesia.
6. **Women:** Anesthetics, medications and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion, and I accept full responsibility for informing the dentist or attending anesthesiologist or anesthetist of a suspected or confirmed pregnancy.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of I.V. sedation/anesthesia and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, or even death which may be associated with any phase of receiving I.V. sedation/anesthesia in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. _____ and/or his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications, for my own benefit or the benefit of my minor child or ward. I understand that the attending anesthesiologist or anesthetist may request that I sign an additional informed consent generated by their office.

Patient's name (please print)

Signature of patient, legal guardian,
or authorized representative

Date

Witness to signature

Date