

Consent for Anesthesia

This is my consent for the Doctor, or any dentist or physician who may be employed by:

_____,
to perform the oral and/or dental procedures indicated on my examination chart, as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned operation.

I also agree to the use of a local, conscious or general anesthetic sedation, and analgesic, depending upon the judgment of the dentists involved with my care.

I have been informed that occasionally there are complications of the treatment, drugs and anesthesia, including pain, infection, swelling, bleeding, discoloration, numbness, tingling of the lip, tongue, chin, gum tissues, cheeks and teeth, pain and numbness and tingling and thrombophlebitis (inflammation of the vein) from intravenous injection, injury to and stiffening of the neck and facial muscles, referred pain to the ear, neck and head, nausea, vomiting, allergic reaction, bone fractures, bruises, or delayed healing.

Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle or hazardous devices, or work, while taking such medications and/or drugs, or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous devices for at least 24 hours, or fully recovered from the effects of such medications, drugs, or anesthetics.

I acknowledge the receipt of pre-operative instructions, and understand that I should have nothing to eat or drink for at least eight hours prior to receiving anesthetics. In addition, I acknowledge the receipt of and understand post-operative instructions and have been given a specific appointment date to return to the office.

I acknowledge that my health history has revealed the following conditions:

1. _____
2. _____
3. _____
4. _____

Because of these conditions, it has been thoroughly explained to me and I completely realize, that any surgical procedure may, therefore, be classified as a risk procedure. The risk involved is defined as a greater possibility of experiencing morbidity (the relative incidence of disease) and mortality (the proportion of death to population) during the surgical procedure than a person in good health. These complications which can occur during surgery may involve more than average amount of post-operative discomfort, increased pain and swelling, and delayed healing. I fully acknowledge that these possible complications have been explained. With clear knowledge of all of these possible complications, I have requested that the procedure be performed in the office environment, rather than the hospital.

I may request further explanations of the risks involved and possible outcome of the procedure. When the patient is a minor or incompetent to give consent, signature should be of a person authorized to consent for the patient.

Signature of Patient or Guardian

Date

Signature of Witness

Date

Signature of the Doctor

Date