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 will be happy 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;
   - 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 over;
   - 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 the use of tobacco and alcohol is detrimental to the success of my treatment.

Patient's Initials __________

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I 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.

____________________________________ ____________

Patient or Legal Representative Signature Date

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Print Patient or Legal Representative Name/Relationship

________________________________ ____________

Witness Signature (optional) Date

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed anesthesia. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

____ ____________

Signature of Provider who will administer anesthesia Date

____

Title

Patient's Initials ___________