Signature Dental

Oral Sedation Consent Form

This form is intended to document the discussion we have had regarding your planned conscious sedation procedure. I _____ understand that my treatment today will include the administration of Nitrous oxide (N2O/O2).I have been informed of the purpose of the procedure and how it will benefit my treatment. The procedure has been described to me and I understand how it will be accomplished. I should feel more relaxed and less anxious. I also understand that I will still be able to communicate with the dentist while treatment is being performed. Even though it is safe, effective and wears off rapidly after the dental visit, I am aware of some important precautions and considerations.

I understand that certain risk (s) may be associated with this procedure, such as headache, dizziness, nausea and vomiting. I also realize that my dentist must know if I have taken any type of medications or drugs within the past seventy-two hours because these may cause an adverse reaction when nitrous oxide is administered. I verify that I have told my doctor about any such medications and drugs.

You should not use these medications if you are pregnant, breast feeding, or have significant liver or kidney disease.

The dentist has reviewed the written instructions with me including expectations regarding food/drink intake, escort and activity after the sedation. Sedation can be administered by multiple routes. Dr. Renda Blair has discussed these options with me. I also understand that the sedation plan may need to be changed on the day of the procedure.

During the discussion, I have had my questions answered to my satisfaction.

I, _____, request and authorize Dr. Renda Blair to administer oral conscious sedation medications and/or nitrous oxide/oxygen conscious sedation and agree to hold harmless, release, and indemnity agents, and employees of the office/clinic of Signature Dental from any and all causes of action, claims, demands or liability that may arise out of such treatment on behalf of myself/child/heir.

The reason I am asking for these medications is: _____.

Patient/Guardian _____Date _____

Witness: _____Doctor:_____

Adult Sedation Patient Instructions

IF PATIENT IS HAVING A COLD, FLU OR RECENT EAR INFECTION PLEASE INFORM US. THE PROCEDURE WILL HAVE TO BE RESCHEDULED.

Last meal must be before 10:00 p.m or 6-8 hours before procedure except for Diabetic patients No food or water (except water with meds) for six hours prior to appointment. Diabetic patients must not go hungry. On the morning of appointment three (3) hours before patient should have light breakfast – cereal, low fat milk, fruit juice, coffee and dry toast.

No sedatives for 24 hours before/after (other than night time anxiolytic prescribed by treating dentist)

No stimulants for 12 hours before/after

No chance of pregnancy breast feeding, or have significant liver or kidney disease.

No sensitivities to Benzodiazepines, Hydrolyzing, Zaleplon

Must have a responsible person to bring and take them home

No contact lenses

The patient will sit in the waiting room for 15-20 minutes until drowsy after which the patient will be escorted to the surgery where the Nitrous gas will be administered.

The patient will become drowsy but still aware of his/her surrounding but very relaxed. This is a mild sedation procedure.

No driving for driving for 24 hours after

No operating hazardous devices

No heavy lifting

No stairs

No important decisions which also includes financial decisions.

So far we have a 90% success rate once the instructions are followed.

Please feel free to express any other concerns. We have your best interest at heart and will answer all concerns.

NB. There is an added cost of $5,000.00 for Sedation procedure.

Oral Sedation Consent Form

This form is intended to document the discussion we have had regarding your planned conscious sedation procedure. I _____ understand that my child's treatment today will include the administration of Nitrous oxide (N2O/O2).I have been informed of the purpose of the procedure and how it will benefit my treatment. The procedure has been described to me and I understand how it will be accomplished. I should feel more relaxed and less anxious. I also understand that I will still be able to communicate with the dentist while treatment is being performed. Even though it is safe, effective and wears off rapidly after the dental visit, I am aware of some important precautions and considerations.

I understand that certain risk (s) may be associated with this procedure, such as headache, dizziness, nausea and vomiting. I also realize that my dentist must know if I have taken any type of medications or drugs within the past seventy-two hours because these may cause an adverse reaction when nitrous oxide is administered. I verify that I have told my doctor about any such medications and drugs.

The dentist has reviewed the written instructions with me including expectations regarding food/drink intake, escort and activity after the sedation. Sedation can be administered by multiple routes. Dr. Renda Blair has discussed these options with me. I also understand that the sedation plan may need to be changed on the day of the procedure.

During the discussion, I have had my questions answered to my satisfaction.

I, _____, request and authorize Dr. Renda Blair to administer oral conscious sedation medications and/or nitrous oxide/oxygen conscious sedation and agree to hold harmless, release, and indemnity agents, and employees of the office/clinic of Signature Dental from any and all causes of action, claims, demands or liability that may arise out of such treatment on behalf of myself/child/heir.

The reason I am asking for these medications is: _____.

Patient/Guardian _____Date _____

Witness: _____Doctor:_____