



IV SEDATION | CONSENT

The following is provided to inform you of the choices, risks and benefits involved with having treatment under parenteral moderate sedation. This information is presented to enable you to be informed regarding the delivery of sedation during your treatment.

I, _____ (PATIENT), hereby authorize:

Dr. _____ (DOCTOR) to perform the sedation procedure as previously explained to me, and any other procedure deemed necessary or advisable as an adjunct to the planned sedation procedure, including:

Planned Treatment: _____.

- I consent to the administration of such sedation by any route suitable by the Doctor. I understand that the Doctor will have full charge of the administration and maintenance of the sedation. **INITIAL HERE:** _____
- I have read, and will comply with, the instructions in the "Pre-Operative Instructions for Dental Treatment with Sedation" & "Sedation Post-Op Instructions" sheets given prior to the sedation procedure. **INITIAL HERE:** _____
- I understand that there are potential complications associated with the administration of sedative drugs including but not limited to: pain, swelling, bruising, phlebitis, numbness, bleeding, nausea, vomiting, drowsiness, lack of awareness, and allergic reactions. I further understand the risk that complications may require hospitalization. **INITIAL HERE:** _____
- I understand that sedative medications and other drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Doctor of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement of the sedation. For the same reasons, I understand that I must inform Doctor if I am a nursing mother. **INITIAL HERE:** _____
- I have been fully advised of and completely understand the alternatives to sedation, and accept the potential risks and dangers. I acknowledge the receipt of both preoperative and postoperative instructions. I have had the opportunity to ask questions about my sedation and I am satisfied with the information provided to me. **INITIAL HERE:** _____
- I hereby authorize the use of photos or film during my dental procedure. Any photo or film will be used purely for educational purposes. **INITIAL HERE:** _____

Patient (Signature) _____ Date: _____

PATIENT RELEASE

I am escorting this patient home. I understand the patient has been sedated. I have received a copy of the post-operative instructions for the sedated patient. I agree to the instructions outlined above. I have had an opportunity to ask any questions I may have, and am comfortable taking responsibility for them.

Escort name (Print) _____ Ph: _____

Escort (Signature) _____ Date: _____