Darius Smith D.D.S., PC

IV Sedation, Extractions, Implants
Periodontal surgery, Root Canals and Consulting

AUTHORIZATION AND CONSENT FOR INTRAVENOUS (IV) CONSCIOUS SEDATION

I, (Print Patient Name) _____hereby authorize Dr. Smith to perform INTRAVENOUS (IV) CONSCIOUS SEDATION and any other procedure deem necessary or advisable as an adjunct to the planned sedation procedure for myself or my child. I consent to the administration of such anesthesia/sedations for my child or myself by any route suitable by Dr. Smith, who is a general dentist. I understand the Dr. Smith, will have full charge of the administration and maintenance of anesthesia/sedation and that this is an independent function from the dental procedure.

I understand that there are potential complication/risks associated with administration of anesthesia/sedative drugs such as but not limited to:

TREATMENT RISKS

1. Nausea and vomiting: this is the most frequent of the side effects of intravenous conscious sedation but its frequency is still quite low. In order to use intravenous conscious sedation you or your child must not have eaten for six (6) hours prior to the procedure.
2. Pain, hematoma, phlebitis, numbness, swelling, bleeding, bruising and potential allergic reaction are also potential side effects of intravenous conscious sedation.
3. I further understand the risk that complications may require hospitalization and can result in cardiac arrest, brain injury and/or death.
4. Local anesthesia may also be required for most procedures as intravenous conscious sedation is used for anxiety and pain control, as well as control of gagging.

PLEASE ADVISE THE DOCTOR AND STAFF IF YOU (OR THE CHILD) HAVE A COLD, UPPER RESPIRATORY INFECTION, ASTHMA OR DIFFICULTY BREATHING. YOU MUST ALSO ADVISE THE DOCTOR AND STAFF IF YOU OR THE CHILD ARE ALLERGIC TO ANY MEDICATION OR HAVE EXPERIENCED ANY PRIOR ADVERSE REACTION TO THE ANESTHESIA OR SEDATION.

I understand that anesthetics, sedatives, medications and other drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risk, I accept full responsibility for informing Dr. Smith of a suspected or confirmed pregnancy with the understanding that this will this necessitate the postponement of the anesthesia/sedation. For the same reasons, I understand that I must inform Dr. Smith if I am a nursing mother.

I HEREBY CERTIFY THAT I UNDERSTAND THIS AUTHORIZATION AND THE REASONS FOR THE ABOVE NAMED SEDATIVE PROCEDURE AND FURTHER CERTIFY THAT THE DOCTOR HAS EXPLAINED THE RISK ASSOCIATED WITH THIS PROCEDURE TO ME. I UNDERSTAND AND EXCEPT THE POTENTIAL RISKS AND DANGERS. I AKNOWLEDGE THE RECEIPT OF BOTH PRE-OPERATIVE AND POST-OPERATIVE WRITTEN INSTRUCTIONS. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE ANESTHESIA/SEDATION, AND I'M SATISFIED WITH THE INFORMATION PROVIDED TO ME. I AM AWARE THAT THE PRACTICE OF DENTISTRY IS NOT AN EXACT SCIENCE. I HAVE KNOWLEDGE THAT EVERY EFFORT WILL BE MADE ON MY (OR THE CHILD'S) BEHALF FOR A POSITIVE OUTCOME FOR SEDATION, BUT NO GUARANTEES HAVE BEEN GIVEN ME AS TO THE RESULT OF THE PROCEDURE I AM HEREBY AUTHORIZING. I HEREBY CONSENT TO THE PERFORMANCE OF INTRAVENOUS (IV) CONSCIOUS SEDATION.

_____

Patient/Parent or Legal Guardian Signature Date

_____

Doctor's Signature Date

_____

Witness Signature Date