FAMILY, IMPLANT & COSMETIC DENTISTRY SINCE 1979

Creating Beautiful Smiles Since 1979

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REQUEST FOR ANESTHESIA, ANXIOLYSIS AND SEDATION CONSENT FORM

It is our moral and legal obligation to give you the information necessary to make an educated decision in requesting treatment. The benefits of therapy are usually greater than the risk, but just as there are risks involved with driving a car, there are events that can occur with any type of treatment. These are being explained to inform and educate you, not to alarm you. Eliminating surprises will make your care go more smoothly. As with any dental procedure you must advise us of your medical status including a complete disclosure of all medications and/or drugs that you are currently taking with special notice to us if you are pregnant or have glaucoma.

Routine Aftermath:

- Minor oozing of blood from the surgery sites, which will require you to use gauze pressure packs for the first 24-36 hours.
- Postoperative discomfort and swelling which may require several days of home recuperation.
- Chapping of the lips caused by stretching the corners of the mouth during surgery.
- Stiffness of the jaws and restricted mouth opening from several days to several weeks depending on the extent of the treatment.
- Possible temporary amnesia.
- Temporary side effects may include but are not limited to ataxia, abnormal gait, confusion and lethargy.

Rare occurrences can include any event that might be remotely possible but unlikely to occur. People rarely plan their lives around these, but are still aware that they can occur. These include: allergic reaction to drugs which range from hives to heart failure. Many drug reactions are side effects and treated as such. The office staff has had training in managing these potential problems.

Medication, 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. It would be wise not to operate any vehicle, automobile or hazardous device while taking such medication and/or drugs. Your judgment and work performance can be altered by pain medication or the sedative agents and you should plan accordingly. Your signature below certifies:

- Your consent and request for **Dr. Schwartz** or any dentist working with him to perform the following treatment, procedure or surgery.
- Full treatment as described in your treatment plan.

- You understand that on rare occasions, individual patient differences can result in relapse of a condition in spite of our efforts. In this event you understand that selective retreatment may be necessary.
- You agree to the administration of anesthesia, nitrous oxide/oxygen and/or sedation as discussed with **Dr. Schwartz** or any dentist working with him.
- You authorize **Dr. Schwartz** to use his best judgment in managing unforeseen conditions which might unexpectedly arise during the course of the procedure.
- You understand that lack of cooperation with our recommendations during your care may result in less than optimum results.
- That you read and write English, understand the above information and have had the opportunity to review and discuss it as well as your health history including any serious problems or injuries.
- That you are both mentally and physically competent to give this consent.

Patient, Parent or Guardian	Date
Doctor	Witness