Informed Consent for Moderate Sedation

1. I_____ parent/guardian of _____authorize Dr. _____ to perform the following procedure(s), in part or in sum as discussed in the treatment planning of care of my child by Dr. _____

Dental exam:	Yes	No	Dental cleaning:	Yes	No	Fluoride:	yes	No
X rays:	Yes	No	Fillings:	Yes	No	Caps:	Yes	No
Pulpotomy:	Yes	No	Removal of teeth:	Yes	No			

During oral sedation the following sedatives will be used: (check that applies and cross out rest)

_____ oral Meperidine, _____oral Hydroxyzine, _____ oral Midazolam

I understand the reason for the procedure(s) to be done under sedation is related to one or more of the following:

Young age, dental anxiety, extent of treatment, medical history or other_____

Alternatives to this procedure have been fully discussed with me by the dentist named above and include no treatment, protective stabilization alone, local anesthesia alone, IV sedation or general anesthesia.

2. **Risks: I give this authorization with the understanding that any procedure may involve certain risks or hazards. I understand that the risks of the procedure(s) include, but are not limited to soreness of mouth, lips, gums and teeth, numbness, nausea, vomiting, fever, bleeding, infection, blood clots, nerve injury, allergic reactions. I understand that sedation risks include, but are not limited to soreness of mouth and nose, numbness, nausea, vomiting, fever, infection, bleeding, nerve injury, blood clots, allergic reactions, pneumonia, aspiration, altered heart and breathing rate, brain damage, or death. These risks may imply serious, possibly fatal consequences.**
3. **Additional procedure**: If my dentist discovers a different unsuspected condition at the time of surgery, I authorize her to perform such procedure that she deems necessary.
4. I hereby authorize the above named dentist to preserve for scientific or teaching purposes, or to dispose of any teeth, or tissues removed as a necessary part of patient's care except as noted:
   _____
5. I consent to taking of photographs and/or videotapes during the procedure for education and teaching purposes.
6. I understand that no guarantee or assurance has been made as to the ultimate result of the procedure.
7. **Patient's consent**: I have read and fully understand this consent form. I understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if do not understand any of the words contained in this form.

Date:_____ Time:_____

_____ _____

Patient or person with authority to consent for patient Relationship to patient

Witness to signature:_____Second witness if telephone consent:_____

Dentist Declaration: I have explained the sontents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge I feel the patient has been adequately informed and have consented to the procedure detailed above.

Dentist's signature:_____ Date:_____ Time:_____