REQUEST FOR | ANESTHESIA & SEDATION

- I consent to the use of Anesthesia & Sedation for my dental treatment, and to the use of the approximate medications administered by my dentist.
- I understand that I will be conscious but deeply relaxed during the procedure.
- My protective reflexes, such as cough reflex, will be intact.
- It is likely that I will remember very little about my procedure afterwards.
- I have been advised that:
  - I must arrange for an escort to pick me up at the office or stay with me during the procedure. This is a person I can trust and I give them consent to make any decisions necessary during my procedure as my decision making ability will be under the influence of the sedation medication.
  - I also understand I must have a ride to my appointment if I take any sedatives prior to my appointment.
  - I understand that my escort must have a valid driver's license.
  - I understand that I should not eat or drink anything for 8 hours prior to the procedure.
  - I should not drive a car or operate heavy machinery for at least 24 hours following the appointment.
  - I understand that I must follow my dentist instructions as to post-operative care following my appointment.
  - I understand that my pulse rate and blood pressure and oxygen saturation will be monitored during this procedure and should the need arise during the procedure; medications may be used to reverse the effects of sedation.
- I understand that there are possible complications including but not limited to an allergic reaction to drugs which range from hives to heart failure, bruising, swelling, and soreness.
- I have advised my dentist of my medical status including a complete disclosure of all medications and/or drugs that I currently take with special notice if I might be or am pregnant or have glaucoma or a bleeding disorder.
- I understand that mixing alcohol or other recreational, illegal or undisclosed prescription drugs may be hazardous to my health and may carry significant side effects.
- I understand that taking drugs can alter my judgment and work performance and I will plan my life accordingly.
- I authorize my dentist to use his best judgment in managing unforeseen conditions, which might unexpectedly arise during the course of the procedure. I understand that lack of cooperation with your recommendations during my care may result in less than optimum results.
- I acknowledge that I am both mentally and physically competent to give this consent, I understand the above information given in English and I have had the opportunity to review, discuss and have all my questions addressed.

PATIENTS NAME (PLEASE PRINT)	SIGNATURE OF PATIENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
WITNESS (PLEASE PRINT)	SIGNATURE OF WITNESS	DATE