INFORMED CONSENT FOR INTRAVENOUS SEDATION

I consent to the use of intravenous sedation for my dental treatment, and to the use of appropriate medications administered by my dentist. I understand that I will be conscious but deeply relaxed during the procedure. My protective reflexes, such as the cough reflex, will be intact, but it is possible that I will remember very little about the procedure afterwards.

I have been advised of the following:

1) I have arranged for someone to pick me up at the office at the conclusion of my appointment and drive me home. I understand that my treatment may not be done if I have neglected to arrange for this.

2) I understand I should eat very lightly prior to the procedure. (such as: small bowl cereal, fruit, or small sandwich)

3) I understand that I could experience drowsiness for up to 48 hours following the procedure. I should not drive a car or operate machinery for at least 24 hours.

4) I understand that I must follow my dentist's instructions as to post-operative care following my appointment.

5) In rare instances, an infection can develop in the arm at the I.V. site. This might be accompanied by redness, bruising, swelling, and soreness that might last several weeks.

6) I understand that my pulse rate and blood pressure will be monitored during this procedure. Should the need arise during the procedure, medications may be used to reverse the effects of the sedation.

I understand this procedure, the risks of the procedure, any alternatives and their risks have been explained to me, as well as the fee(s) involved.

Signature:______________________________________ Date:______________

Witness: _______________________________________