Consent for the Use of Orally Administered Conscious Sedation

An explanation of orally administered sedation, its purpose and benefits, the procedure and drugs used and the possible complications of its use as well as alternatives to its use were discussed with you at your consultation. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

ALTERNATIVE TYPES OF ANESTHESIA: I have been informed that my treatment can be performed with a variety of types of anesthesia: (1) local anesthesia as normally used for minor dental treatment; (2) local anesthesia supplemented with orally administered conscious sedation; (3) local anesthesia supplemented with orally administered conscious sedation; and (4) general anesthesia in the hospital or out-patient day care surgical center. I have been made aware that the risks with each type of anesthesia vary, with local anesthesia generally considered to have the least risk and general anesthesia having the greatest risk. I have been advised that if I am significantly subject to fear, anxiety or emotional stress related to dental procedures, or if a long or stressful procedure is to be undertaken, or if certain medical or physical conditions exist, this risk sequence can change, and conscious sedation, properly administered, might be beneficial relative to other anesthetics alternatives. I understand that, based on the doctor's judgment, one or more of the choices for anesthesia may not be desirable in every case.

THE PROCESS OF ORALLY ADMINISTERED CONSCIOUS SEDATION: I have been informed that the objective of conscious sedation is to lessen the significant and undesirable side effects of long and stressful dental procedures by chemically reducing the fear, apprehension, emotional and physical stresses sometimes present. This is accomplished by the ORAL administration of small doses of various medications such that they produce a state of relaxation, reduced perception of pain and a degree if drowsiness, but that I will not be put to sleep as with a general anesthetic. In addition, local anesthetics will be administered in my mouth to numb the areas to be operated so as to control pain. I also understand that other drugs may be used to alter my reaction to these drugs or to enhance my physical status during the procedure.

POSSIBLE RISKS AND SIDE EFFECTS: I have been informed and understand that occasionally there are complications associated with oral sedation including but not limited to: nausea, hallucinations, vomiting, allergic reaction, and in extremely rare instance, brain damage or death.

PATIENT COMPLIANCE: I agree to the following: (1) I will refrain from eating for 4 hours prior to my dental appointment; (2) I will refrain from consuming any alcoholic beverages for 12 hours before and 24 hours following this procedure; (3) I will disclose to the doctor any and all drugs and medications I am currently taking; (4) I have disclosed any abnormalities in my current physical status or past medical history including any history of drug or alcohol abuse or any abnormal reactions to any drugs/medications which I have taken; (5) I will arrange for a responsible adult to drive me home and be with me until the effects of the sedation have worn off; and (6) I will refrain from driving a motor vehicle or operating dangerous machinery for the remainder of the day I received sedation.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to periodontal flap surgery with osseous regeneration by the use of demineralized bone allografts as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

_____	_____	_____
Patient's Signature	Date	Patient's Name (please print)
_____	_____	_____
Signature of Patient's Guardian	Date	Relationship to Patient
_____	_____	
Signature of Witness	Date	