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Consent for Treatment

I, _____, authorize **Deep Sedation/General Anesthetic** for my dental treatment. The nature and purpose of the sedation, possible alternatives, associated benefits and risks involved, and potential complications have been explained to me in a well-informed manner, which I understand.

My choices are that the dental treatment can be done using local anesthetics alone, or in combination with moderate/deep sedation or general anesthesia for the purpose of relaxation and reducing my level of anxiety.

I am aware that the most common complication from deep sedation/general anesthesia is drowsiness. On occasion, there may be nausea, vomiting, sore throat or tenderness/bruising around the intravenous site. I understand that on rare occasions there can be complications from deep sedation/general anesthesia including allergic reaction. Also, on *extremely* rare occasions, there may be complications that require emergency hospital care and/or hospitalization.

I am aware that I should avoid alcoholic drinks for 24 hours after receiving sedation. I should not operate any machinery, drive automobiles, make important decisions, or sign any documents for 24 hours after receiving sedation. I will have a responsible adult accompany me home after my appointment by car or taxi only.

I understand that certain medications may be harmful to an unborn child, and so should I be pregnant or suspect myself to be, I will inform the anesthesiologist or the treating dentist of my situation, which may result in delaying my treatment. I will also inform the doctor if I am currently breast-feeding my child. In general, the agents used are safe, but this will be discussed with me.

I authorize Dr. Caudry, her associates, and the anesthesiologist to contact my physician or other healthcare professionals for the purpose of obtaining any additional health or medical information about myself should it be deemed important by the anesthesiologist for the purpose of administering sedation.

I am aware that I wlll be medicated and/or anesthetized (“put asleep”) while being treated, and will likely be in a state that interferes with my normal ability to give instructions and make decisions. Once any treatment begins, I authorize Dr. Caudry and/or her associates to make decisions to change my treatment plan if they feel doing so is appropriate and in my best interests. Dr. Caudry and her associates may then do so without consulting with me if they believe this may be necessary to address any situation that may arise.

I have authorized Dr. Caudry and her associates to do the prescribed surgery during the anesthesia, have had the opportunity to ask questions, and am satisfied with the information provided to me.

Patient Signature_____ Date: _____

Print Name: _____