



Informed Consent Documentation for Conscious Sedation

This form is intended to document the discussion we have had regarding your planned conscious sedation procedure. This form does not include the risks or benefits of the procedure being performed in conjunction with conscious sedation.

I, _____, request and authorize Dr. McEntire, a general dentist with advanced sedation training, to administer conscious sedation medications to me in conjunction with a dental procedure being completed in this office.

Benefits of conscious sedation include reduced awareness of unpleasant sights, sounds and sensations associated with the dental procedure. Reduced anxiety should also be present.

Risks of conscious sedation include nausea, vomiting, drowsiness, and fatigue. Other less common risks include allergy to medication, irritation and/or pain/swelling to skin and veins, bruising of tissue, breathing problems, brain damage, cardiac arrest and even death.

I understand that it is critically important that I fully discuss my complete medical history with the doctor before sedative medications are administered. **Failure to do so could have a detrimental outcome to my health or well-being.**

The doctor has reviewed the written instructions with me including expectations regarding food/drink intake, escort and activity after the sedation.

I acknowledge that no guarantee has been made as to the results that may be obtained. I understand that my dental work may not be completed as planned if complications arise during the sedation.

Sedation can be administered by multiple routes (oral, intramuscular, intravenous, intranasal, inhalation, submucosal). The doctor has discussed these options with me. I also understand that the sedation plan may need to be changed on the day of the procedure.

I certify that I have had an opportunity to read and fully understand the terms and words within the above consent. During the discussion, I have had my questions answered to my satisfaction.

Patient: _____

Date: _____

Witness: _____

Date: _____

Dentist: _____

Date: _____