

**I understand** that undergoing **Anesthesia/I.V. Sedation** is to more comfortably receive necessary care. I.V Sedation is not required to provide the necessary dental care. I understand that I.V. has limitations and risks and absolute success cannot be guaranteed. Nevertheless, I agree to assume those risks and possible unsuccessful results associated with, but not limited to the following:

**\_\_\_I acknowledge that I have read and signed this Informational Informed Consent form prior to my receiving any form of Anesthesia/I.V Sedation.**

- 1. Complications of the Drugs and Anesthesia, including but not limited to:** tenderness, bruising, nausea, vomiting, swelling, bleeding, infection, numbness, allergic reaction, stroke, and heart attack. Some of these complications, although rare, may require hospitalization and may even result in death.
- 2. Bruising or Tenderness of the I.V Induction Site May Occur:** Some sedative agents may cause a burning or itching sensation in the wrist or arm during induction. Edema may be caused when excess I.V. fluid enters surrounding tissues and may take several days to resolve. Sometimes phlebitis (inflammation of the venipuncture site) may require additional treatment. Tenderness/edema can be treated with warm moist heat applied to the site.
- 3. Need for Limitation of Food or Drink:** The patient must refrain from any food or drink after midnight prior to a morning appointment. Prior to an afternoon appointment the patient is limited to a light breakfast no later than six hours before treatment time and clear liquids up to three hours before treatment. Further instructions may be given by the dentist or anesthesiologist or anesthesiologist depending on the procedures to be performed and other factors.
- 4. Changes in Health are Important:** Changes in health including but not limited to, fevers or "common colds" can cause complications with the treatment and/or sedation. I understand I am expected to convey this information to the dentist prior to a planned appointment when sedation/anesthesia is involved.
- 5. A Responsible Adult Must Accompany the Patient at the Time of Discharge:** By signing this form I agree not to drive, take a bus or taxi for 24 hours after the I.V Sedation and understand that I am responsible for arranging for my own transportation to and from the dental office. I also agree not to drive or operate any machinery during the 24 hours. I agree to have someone stay with me for several hours after sedation due to possible disorientation and to prevent possible injury from falling due to disorientation, loss of balance, etc.
- 6. I authorize the dentist to use his best professional judgment in managing unforeseen conditions** which might unexpectedly arise during the course of oral sedation and the planned dental procedures. I understand that I have the right to designate the individual who will make such a decision. I acknowledge that lack of cooperation with recommendations made concerning dosage and other protocols associated with oral sedation may contribute to less than desired results.
- 7. Women:** Anesthetics, medications and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion, and by signing this form the patient accepts full responsibility for informing the dentist or attending anesthesiologist or anesthesiologist of a suspected or confirmed pregnancy.

**I understand that it is my responsibility to notify Gunnerson Dental should any undue or unexpected problems occur** or if I experience any problems relating to the treatment rendered or the services performed.

**Informed Consent:** I have been given the opportunity to ask any questions regarding the nature and purpose of **I.V. Sedation/Anesthesia** and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, or even death which may be associated with any phase of receiving I.V. sedation/anesthesia in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize this practice and/or their associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications, for my own benefit or the benefit of my minor child or ward. I understand that the attending anesthesiologist or anesthesiologist may request that I sign an additional informed consent generated by their office. I understand it is my responsibility to notify the dentist and/or his associates of ALL the medications I am currently taking as well as any allergies.

Patient Name	Signature of patient, legal guardian, or authorized representative	Date
Tooth Number	Witness Signature	Date

## Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. It is my responsibility to inform the dental office of any changes in medical status.

I consent to use Electronic Records and Signatures.: [ ]

Relation to Patient: