

I UNDERSTAND that dental treatment requiring NITROUS OXIDE PROCEDURES, which I desire to have performed, includes certain risks and possible unsuccessful results or procedural failure. Even though care and diligence will be exercised in this treatment, there are no guarantees of desired or anticipated results, or of the longevity of the treatment. I AGREE to assume the risks, to the possibility of unsuccessful results or procedural failure associated with the treatment, and to the following statements:

I understand nitrous oxide, commonly called "laughing gas", is used to provide relaxation during dental procedures. I understand that I, or my legal dependent, will be fully awake, aware of my/their surroundings, able to obey commands, and respond to questions and instructions.

I have advised the doctor/staff of my medical history, and/or have updated them on any changes to my medical history, including, but not limited to: head colds, upper respiratory infections, breathing problems, asthma, lung disease, or any surgeries.

I understand local anesthetic will also be required for most dental procedures. Nitrous oxide sedation is administered to help reduce anxiety and apprehension and does not block pain or discomfort.

I understand and accept nitrous oxide is an elective procedure and is not required for needed dental treatment, and additionally understand the possible complications associated with nitrous oxide which include, but are not limited to: nausea and vomiting, sluggishness in speech and movement, tingling in the extremities, and possibly the entire body, generalized warmth with possible flushing or blushing of the skin, feeling of floating or dream-like state, and coldness with possible shivering.

I understand nitrous oxide sedation is very effective for most people. However, some may develop unwanted or adverse reactions. If that should occur with my treatment, the dentist may decide to discontinue its use for my dental procedure.

I understand that nitrous oxide sedation may not produce the calming effect that I desire, and that I may require other sedative drugs for my procedure. If I elect additional sedative drugs or modalities for my anxiety, it may require another appointment to proceed with my needed dental care, and that

additional charges may be required.

I authorize the dentist to use his/her best judgment in managing unforeseen conditions which might unexpectedly arise during the course of nitrous oxide and the planned dental procedures. I acknowledge that my lack of cooperation with recommendations made for nitrous oxide and oxygen levels of flow, and other protocols associated with nitrous oxide therapy, may contribute to less than desired results.

It is my responsibility to contact the dentist and seek attention should any abnormal postoperative circumstances occur.

I will diligently follow any preoperative and postoperative instructions given to me.

## VOLUNTARY INFORMED CONSENT TO TREATMENT

As indicated by my initials above and my signature below, the doctor and dental team have given me the opportunity to read this document in its entirety and have allowed me to ask any and all questions pertaining to the procedure(s) above, their nature and purpose. They have also explained to me alternative forms of treatment and the risks of nontreatment. They have answered all my questions and concerns to my satisfaction with language I could understand. I voluntarily assume any and all possible risk, including risk of substantial harm, if any, which may be associated with any phase of this, or any unforeseen additional, dental treatment in hopes of obtaining the desired results for me, or for my minor child or ward. I also voluntarily assume the risk that the desired result may not be achieved. I have also been given the option to seek treatment from a specialist. No guarantees or warranties have been made to me concerning the results. Moreover, the fee(s) associated with these services have been explained to me, and I accept the financial responsibilities.

By signing this form, I am willingly, under no duress, giving my consent to allow and authorize the doctor, dental team members, and their associates, to render any treatment they believe necessary, appropriate, and/or beneficial to me, or my minor child or ward, including the administration and prescribing of any/all anesthetics and/or medications.

I consent to use Electronic Records and Signatures: [ ]