

**I understand** that the purpose of **Anxiolysis (Medications to aid anxiety)** is to more comfortably receive necessary care. Anxiolysis is not required to provide the necessary dental care. I understand that anxiolysis has limitations and risks and absolute success cannot be guaranteed. Nevertheless, I agree to assume the risks, possible unsuccessful results and/or failure associated with the recommended treatment.

**I understand that Anxiolysis is a drug-induced state of reduced awareness** and decreased ability to respond. The purpose of anxiolysis is to reduce fear and anxiety. The patient will be able to respond and communicate during the procedure. The patients regular ability to respond will return when the effects of the sedative wear off.

**\_\_\_\_\_ I acknowledge that I have read and signed this Informational Informed Consent form prior to my taking any form of Anxiolysis.** I understand the the purpose of Anxiolysis is to more comfortably receive necessary care. Anxiolysis is not required to provide the necessary dental care. I understand that Anxiolysis has limitations and risks and absolute success cannot be guaranteed.

**1. I understand there are alternatives to Anxiolysis, such as:**

- A. No Sedation:** The necessary procedure is performed under local anesthetic with the patient fully aware.
- B. Nitrous Oxide Sedation:** Commonly called laughing gas, nitrous oxide provides relaxation but the patient is still generally aware of surrounding activities. It's effects can be reversed in approximately five minutes with oxygen.
- C. Oral Conscious Sedation:** Sedation via pill form that will put the patient in a minimally depressed level of consciousness.
- D. Intravenous Administration:** The doctor administers the sedative via a tube connected to a vein in the patient's arm. The patient would have to be referred to a specialist for this treatment.
- E. General Anesthetic:** Commonly called deep sedation, a patient under general anesthetic has no awareness and must have their breathing temporarily supported. General anesthesia is more appropriate for longer procedures, lasting 3 hours or more. The patient would have to be referred to a specialist for this treatment.

**2. Oral Administration:** Anxiolytic medications such as; alprazolam (Xanax), diazepam (Valium), lorazepam (Ativan) etc, are taken orally in the pill form. For anxiolysis prescribed for dental treatment, dosage should be taken 1 hour prior to the start of the patients reservation. In order to achieve the best results the patient will need to follow all medication instructions exactly.

**3. Inadequate initial dosage:** Due to the body's natural ability to absorb and respond to medications an additional dosage, undergoing the procedure without anxiolysis, and/or postponing the procedure may be necessary.

**4. Atypical Reaction to Drugs:** In rare cases the patient may have a severe reaction to the medications requiring emergency medical attention and/or hospitalization. Some of these symptoms may be; altered mental states, physical or allergic reactions (skin rash, bruising, bleeding, swelling, etc.) and other illnesses. Should the patient experience any of these symptoms they should stop taking the medication immediately and call this office. If the symptoms are severe, patient should seek medical attention and stop taking the medication before calling this office.

**5. Medical Conditions:** It is the patient's responsibility to notify the doctor if they are pregnant or lactating/breastfeeding. The patient must notify the doctor if they have sensitivity to any medication, present mental and physical condition, if they have recently consumed alcohol, and if they are presently on psychiatric mood altering drugs or other medications.

**6. I authorize the dentist to use his best professional judgment in managing unforeseen conditions** which might unexpectedly arise during the course of sedation and the planned dental procedures. I understand that if I am not comfortable with communicating dental decisions after having taken an anxiolytic medication I have the right to designate an individual who will make such a decision. I acknowledge that lack of cooperation with recommendations made concerning dosage and other protocols associated with Anxiolysis may contribute to less than desired results.

**7. I agree not to drive to or from the office for 24 hours after taking any sedative medication,** and I 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.

**Informed Consent:** I have been given the opportunity to ask any questions regarding the nature and purpose of **Anxiolysis (Medications to aid anxiety)** and have received answers to my satisfaction. I acknowledge that anxiolysis is an option and not absolutely necessary for dental treatment but, nevertheless, I accept this option. I do voluntarily assume any and all possible risks including, but not necessarily limited to those listed above, including risk or substantial harm or even death, which may be associated with anxiolytic drugs. I acknowledge that planned treatment may be postponed or terminated if anxiolytic drugs do not provide the desired effect, and I acknowledge that no guarantees or promises have been made to me concerning the efficacy of anxiolytic sedation in my case or the case of my minor child or ward for whom I give consent for this procedure. The fees for anxiolysis have been explained to me and are satisfactory. By signing this document I am freely giving my consent to allow and authorize this practice and/or their associates or agents to render oral sedation as deemed appropriate and/or advisable to my dental condition, including prescribing and administering appropriate anesthetics and/or medications. I understand it is my responsibility to notify the dentist and/or his associates of ALL the medications I am currently taking.

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Patient Name	Signature of patient, legal guardian, or authorized representative	Date
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Witness Signature	Date
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## 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: