CONSENT FOR ORAL CONSCIOUS SEDATION

I understand that oral conscious sedation is the elective administration of an oral sedative medication, such as Halcion (Triazolam) or Valium (Diazepam), to reduce the fear and anxiety related to dental treatment. Oral conscious sedation can be administered with or without the use of Nitrous Oxide. I understand that conscious sedation is not sleep, and the patient will be able to respond and breathe on their own during the procedure, but will have a reduced state of awareness and decreased reaction or response time.

I understand that the alternatives to oral conscious sedation include no sedation, Nitrous Oxide sedation, IV sedation, and general anesthesia.

I understand that the risks involved with oral conscious sedation include inadequate sedation, atypical drug reactions, and the inability to discuss treatment options with the doctor should circumstances change during my dental treatment.

Initials____

I understand that I can authorize the treating Dentist to proceed with any changes in treatment based on their professional judgment without the consent of a third party.

I understand that I have the right to designate another individual to discuss any changes in treatment with the treating dentist while I am sedated.

____ I authorize the treating dentist to proceed with any changes to the currently planned dental treatment, if changes arise while I am sedated.

____ I authorize _____ to make the decision on my behalf to change my treatment plan as advised by the treating dentist.

I confirm that pre-operative directions were provided and reviewed with me prior to today's appointment. I confirm that the following instructions have been followed in preparation for today's sedation appointment:

_____ No solid food 8 hours before the scheduled sedation appointment

_____ No liquids 2.5 hours before the scheduled sedation appointment

_____ I have taken only the medications I routinely take

_____ I have not taken any "street drugs" in the 2 weeks prior to the scheduled sedation appointment

_____ I have a responsible adult to drive me home, and to stay with me during recovery

_____ I have disclosed any changes in health, especially the development of a cold, fever, cough, or runny/stuffy nose, within 3 days of the scheduled sedation appointment

_____ I am not pregnant or nursing

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of oral conscious sedation, and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any. No guarantees or promises have been made to me concerning the results of treatment to be rendered to me. The fees 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 the doctors at Thrive Dental & Orthodontics to render any treatment necessary or advisable to my dental conditions.

_____

Patient's Name (please print)

_____ _____

Signature of Patient, Legal Guardian, or Authorized Representative Date

_____ _____

Witness' Signature Date