CANYON RIDGE ENDODONTICS

ORAL CONSCIOUS SEDATION INFORMED CONSENT FORM

Oral conscious sedation utilizes the elective administration of an oral sedative medication during dental procedures to reduce the fear and anxiety related to the experience.

The purpose of this document is to ensure that you understand oral conscious sedation and consent to its use during your dental treatment. Please read each item carefully and initial next to the number after you have had the opportunity to discuss it with the attending dentist, and your questions and concerns, if any, have been answered to your satisfaction.

1. I understand that the purpose of oral conscious sedation is to more comfortably receive necessary dental treatment and that it has limitations and risks, and its absolute success cannot be guaranteed.
2. I understand that oral conscious sedation Is a drug induced state of reduced awareness and may decrease my ability to respond. The sedative will not put me to sleep and I will be capable of responding during the procedure. My ability to respond normally will return when the effects of the sedative wear off.
3. I understand that the sedative prescribed will be a pill that I will take as directed before my scheduled appointment.
4. I understand that there maybe an additional fee to utilize this service.
5. I understand that the alternatives to oral conscious sedation are:
    a. No sedation: Treatment is performed using a local anesthetic and the patient is fully aware of surrounding activity.
    b. Anxiolytics: A sedative pill is taken prior to treatment to reduce anxiety and fear.
    c. Nitrous oxide sedation: Provides relation through inhalation of the gas, and the patient is still generally aware of surrounding activity. Its effects are rapidly reversed with the administration of oxygen.
6. I have been informed that there are risks and limitations to all dental procedures. Additionally, with the use of oral sedation, the following risks are also present:
    a. Inadequate sedation with the initial dosage which may require undergoing the procedure without full sedation or having to reschedule the procedure.
    b. Atypical reaction to the sedative drug which may require emergency medical attention and/or hospitalization such as, but not limited to altered mental state, adverse physical reaction, allergic reaction or other unforeseen sicknesses.
    c. The inability to discuss treatment options during the procedure should the circumstance arise, that requires the dentist to change the treatment plan.
7. If, in the professional judgment of the attending dentist, a change in treatment is indicated, I authorize him/her to proceed with it. I also understand that I have the right to designate another individual to discuss any changes of treatment with the dentist.
8. I authorize _____ to make the decision on my behalf to change my treatment plan as advised by the attending dentist.
9. I have had the opportunity to discuss oral conscious sedation with attending dentist and have had all my questions answered to my satisfaction.
10. I understand an agree to follow all the instructions given to me.
11. I have informed the attending dentist of and/or agree to the following:
    a. I am not pregnant or breast feeding.

b. I have disclosed all medications and supplements that I currently take.
c. I have disclosed any known allergies.
d. I am of sound mental and physical ability to make the decision to use oral conscious sedation, and I understand what it is not.
e. I will NOT consume alcohol within 24 hours of using oral conscious sedation.
f. I understand that I will NOT be able to drive or operate machinery for 24 hours after completion of my treatment.
g. Arrangements have been made for transportation to and from my scheduled appointment, and for a responsible adult to stay with me for 12 hours following any appointments during which I have been sedated.

I CONSENT TO THE USE OF ORAL CONSCIOUS SEDATION TO BE USED IN CONJUCTION WITH MY DENTAL TREATMENT.

_____ _____

PATIENT/GUARDIAN DATE

_____

WITNESS