BALLARD FAMILY
DENTISTRY
Jonathan C. Su, DDS

Consent Documentation for Dental Sedation Procedures

1. I authorize and direct Dr. Su to perform upon myself or ______________________ the following dental procedure: Conscious sedation with or without nitrous oxide/oxygen sedation.
2. I understand, through discussions with Dr. Su, the nature and purpose of this procedure. I also understand what alternative treatments are available and the advantages and disadvantages of each, including no treatment. The alternative treatments that have been discussed are: no sedation, fear counseling, referral to a dentist who will use IV sedation or general anesthesia including going to the hospital for a general anesthetic.
3. I understand that there are various risks, consequences, or complications that may result from performing this procedure. I acknowledge that some of the risks, consequences, or complications include, but are not limited to: nausea, hallucinations, amnesia of the procedure, hyperactivity (being more active than normal), dizziness, loss of coordination, sleepiness, laughing or crying. All should resolve quickly once you are back breathing room air.
4. I understand that I may have to stay in the dental office for a while until I am completely back to normal. I do not have Chronic Obstructive Pulmonary Disease (COPD), emphysema, a cold or flu nor am I pregnant.
5. I understand that there is no guarantee that the dental procedure will be successful; however, the procedure is desired and intended to result in improved oral conditions.
6. I agree that a verbal discussion with Dr. Su has outlined why the procedure is recommended, what alternative treatments are available, what risks, consequences, and complications may result from the procedure, and all my questions have been answered satisfactorily. I also agree that all the blanks above on the consent form were filled in before I was asked to sign it. I understand that I must have a driver to and from my appointment. And someone to stay with me after my appointment until the medication has worn off.
7. I understand that I have divulged pertinent medical information that may have consequences with oral sedation.

PATIENT NAME ______________________ DATE ______________

SIGNATURE ______________________

RELATIONSHIP TO PATIENT ______________________

Doctor: I certify that I have discussed the above with the patient and all blanks were filled in before signing.

DR. ______________________

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