

CONSENT FOR ENDODONTIC ANESTHESIA

Patient Name _____ Date _____

Please initial each paragraph after reading.
If you have any questions, please ask your doctor BEFORE initialing.

The purpose of this document is to provide an opportunity for patients to understand and give permission for sedation when provided along with dental treatment.

I hereby authorize Dr. Russin and Staff to perform the following procedure:

_____ and to administer the anesthesia that I have chosen, which is:

- Local Anesthesia
- Nitrous Oxide/Oxygen Analgesia
- Intravenous Sedation

Other treatment options: _____

- _____ 1. I understand that the purpose of sedation is to more comfortably receive necessary care. Sedation is not required to provide the dental care, but can provide a more relaxed and enjoyable experience during treatment.
- _____ 2. I understand that sedation is a drug-induced state of reduced awareness and a decreased ability to respond. The purpose of sedation is to reduce fear, pain, and anxiety. I will be able to respond during the procedure, however, a certain degree of amnesia may occur from the medications. My ability to respond and remember returns normally when the effects of the sedative wears off.
- _____ 3. ANESTHETIC RISKS include: discomfort, swelling, bruising, infection, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability, and may require special care. Nausea and vomiting, although uncommon, may be an unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the rare risks of heart irregularities, heart attack, stroke, brain damage or death.
- _____ 4. YOUR OBLIGATION IF IV ANESTHESIA IS USED
 - A. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are recovered sufficiently to care for yourself. This may be up to 24 hours.
 - B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
 - C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!
 - D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or medications provided by this office, using only a small sip of water.

- ____5. I understand that no guarantee can be promised, and I give my free voluntary consent for treatment. I realize that my doctor may discover conditions requiring different treatment from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgment. I also have the right to designate an individual who will help make such a decision.
- ____6. I understand that I must notify the doctor prior to the administration of sedation of the following:
- A. All current prescribed medications by my doctor(s) and all over the counter medications, or holistic preparations.
 - B. Any allergies or sensitivities to any medications or materials that I know of.
 - C. My current physical and mental condition and any past medical issues that could or did effect previous anesthesia experiences.
 - D. Any recently consumed alcohol, and if I am presently on any psychiatric, mood altering, or other recreational drugs.
- ____7. I have the right to speak to the doctor or staff about any issue in private that could affect my sedation or treatment.

INFORMATION FOR FEMALE PATIENTS:

- ____1. I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.
- ____2. I understand that I must notify the doctor if I am pregnant, attempting to be pregnant, or breast feeding.

CONSENT:

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed treatment and anesthesia. I certify that I can speak, read and write English.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness's Signature

Date