# ORAL SEDATION / ANESTHESIA

Patient Name: _____ Procedure: _____

I have requested an oral sedative: Valium Halcion Ativan (other) _____, Dosage _____ to help relieve anxiety and/or apprehension. I understand the sedative may cause dizziness, drowsiness, time constriction, motor incoordination and fatigue. I understand that I must have an adult transport me to the office and home afterwards. I understand that I will be under the influence of the sedative for 8 to 10 hours and agree to stay at home under the supervision of an adult and will not attempt to drive, supervise or care for any children, or perform anything that requires coordination or personal judgment. I understand that I can NOT have any alcohol, tranquilizers or other sedatives on the day of the treatment – either before or after treatment.

Anesthesia includes:

Local Anesthesia: Novocaine, Lidocaine, etc. to block pain pathways in a localized area.

Local Intranvenous Sedation or General Anesthesia: alters your awareness of the procedure by producing sedative/amnesic effects or sleep.

I understand there are risks involved with both anesthesia and oral sedation that can include, but are not limited to:

1. Nausea and vomiting
2. Temporary partial numbness to face or tongue
3. Unexpected allergic reaction
4. Pain, swelling, bruising or inflammation to the area of injection
5. Prolonged disorientation, confusion or drowsiness after treatment
6. Respiratory or cardiovascular responses which may lead to stroke, heart attack or death

**I also understand and agree that prior to any anesthesia I will not ingest any fluids or solids by mouth for six (6) hours prior to the dental procedure as this could be life-threatening.**

I understand I must have an adult transport me to the office and home afterwards. I understand that I will be under the influence of the sedative for 8 to 10 hours and agree to stay at home under the supervision of an adult and will not attempt to drive, supervise or care for children, or perform anything that requires coordination or personal judgment.

I also agree that I have provided a complete and truthful medical history, to include all medications, drug use, pregnancy, etc.

We invite your questions concerning this or related procedures and their risks. By signing below you acknowledge that you have read this document, understand the information presented, understand that you may see a specialist and are choosing care from the treating dentist and have had all your questions answered satisfactorily.

Additional comments: _____

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Witness: _____ Date: _____