SEDATION DENTISTRY NW
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ALLENMORE MEDICAL CENTER, SUITE B-6001
TACOMA, WA 98405
(253) 572-2822

ORAL / INJECTION SEDATION CONSENT FORM

Patient Name: _____ Procedure: _____

I have requested a sedative: **_____** to help relieve anxiety and/or apprehension. I understand the sedation 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 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 treatment-either before or after treatment.

Anesthesia can include:

- Local Anesthesia: Septocaine, Lidocaine, etc. to block pain pathways in a localized area.
- Oral or intra-muscular administration of sedative agent.
- Nitrous Oxide administration.

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

1. Nausea and vomiting
2. Alters your awareness of the procedure by producing sedative/amnesic effects or sleep
3. Temporary partial numbness to face or tongue; which in very rare occurrences may be present.
4. Unexpected allergic reaction
5. Pain, swelling, bruising, or inflammation to the area of injection.
6. Prolonged disorientation, confusion, or drowsiness after treatment.
7. 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 drink clear liquids only and not ingest any solids by mouth for four (4) hours prior to the dental procedure as this could alter the effect of the sedation.

I understand I must have an adult transport me to the office and home afterwards. I understand 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: _____