JARED E WILLIAMS
DDS

***"Mobile General Dentist
Providing Surgical and Implant Services"***

## AUTHORIZATION AND CONSENT FOR INTRAVENOUS (IV) CONSCIOUS SEDATION

I, (Print Patient's Name) ________________________________hereby authorize Dr. Williams to perform INTRAVENOUS (IV) CONSCIOUS SEDATION and any other procedure deemed necessary or advisable as an adjunct to the planned sedation procedure for myself or my child. I consent to the administration of such anesthesia/sedation for my child or myself by any route suitable by Dr. Williams, who is a general dentist. I understand the Dr. Williams, will have full charge of the administration and maintenance of anesthesia/sedation and that this is an independent function from the dental procedure.

I understand that there are potential complication/risks associated with administration of anesthesia/sedative drugs such as, but not limited to:

**TREATMENT RISKS**

1. Nausea and vomiting: this is the most frequent of the side effects of intravenous conscious sedation but its frequency is still quite low. In order to use intravenous conscious sedation you or your child must not have eaten for six (6) hours prior to the procedure.
2. Pain, hematoma, phlebitis, numbness, swelling, bleeding, bruising and potential allergic reactions are also potential side effects of intravenous conscious sedation.
3. I further understand the risk that complications may require hospitalization and can result in cardiac arrest, brain injury and/or death.
4. Local anesthesia may also be required for most procedures as intravenous conscious sedation is used for anxiety and pain control, as well as control of gagging.

**PLEASE ADVISE THE DOCTOR AND STAFF IF YOU (OR THE CHILD) HAVE A COLD, UPPER RESPIRATORY INFECTION, ASTHMA OR DIFFICULTY BREATHING. YOU MUST ALSO ADVISE THE DOCTOR AND STAFF IF YOU OR YOUR CHILD ARE ALLERGIC TO ANY MEDICATION OR HAVE EXPERIENCED ANY PRIOR ADVERSE REACTION TO THE ANESTHESIA OR SEDATION.**

I understand that anesthetics, sedatives, medications and other drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing Dr. Williams of a suspected or confirmed pregnancy with the understanding that this will this necessitate the postponement of the anesthesia/sedation. For the same reasons, I understand that I must inform Dr. Williams if I am a nursing mother.

I HEREBY CERTIFY THAT I UNDERSTAND THIS AUTHORIZATION AND THE REASONS FOR THE ABOVE NAMED SEDATIVE PROCEDURE AND FURTHER CERTIFY THAT THE DOCTOR HAS EXPLAINED THE RISK ASSOCIATED WITH THIS PROCEDURE TO ME. I UNDERSTAND AND ACCEPT THE POTENTIAL RISKS AND DANGERS. I AKNOWLEDGE THE RECEIPT OF BOTH PRE-OPERATIVE AND POST-OPERATIVE WRITTEN INSTRUCTIONS. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE ANESTHESIA/SEDATION, AND I AM SATISFIED WITH THE INFORMATION PROVIDED TO ME. I AM AWARE THAT THE PRACTICE OF DENTISTRY IS NOT AN EXACT SCIENCE. I HAVE KNOWLEDGE THAT EVERY EFFORT WILL BE MADE ON MY (OR MY CHILD'S) BEHALF FOR A POSITIVE OUTCOME FOR SEDATION, BUT NO GUARANTEES HAVE BEEN GIVEN ME AS TO THE RESULT OF THE PROCEDURE I AM HEREBY AUTHORIZING. I HEREBY CONSENT TO THE PERFORMANCE OF INTRAVENOUS (IV) CONSCIOUS SEDATION.

______________________________________________________________________________
Patient/Parent or Legal Guardian's Signature                                        Date

______________________________________________________________________________
Doctor's Signature                                        Date

______________________________________________________________________________
Witness' Signature                                        Date

ANESTHESIA    ORAL SURGERY    IMPLANTOLOGY    ENDODONTICS

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