

DENTAL ILLUSIONS

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NITROUS OXIDE/OXYGEN INHALATION SEDATION PATIENT CONSENT FORM

To help lower your anxieties about dental treatment and make the appointment more pleasant for you, we plan to add the use of inhalation (breathing) sedation [nitrous oxide and oxygen gasses (also called 'twilight sleep' or 'laughing gas')], and use of local anesthetic (shots). In rare cases, patients may have problems despite our best efforts. The problems include but are not limited to feeling sick to your stomach or throwing up, allergic reactions, breathing problems, heart problems and blood pressure problems. On very rare occasion patients have had to be hospitalized with a life-threatening problem.

FEMALES: If you suspect or know that you are pregnant, it is important that you tell us right now! There is a possible risk to your unborn baby which we need to explain to you, and also a higher risk for sudden miscarriage or loss of the baby.

Treatment to be rendered today: _____

I have read the above and was given the chance to ask more questions. I freely give my informed consent for the use of inhalation (breathing) sedation during the dental procedures outlined above. I understand that no guarantees are made regarding any medical or mental results associated with this technique.

Patient Signature

Date

Printed Name

Witness

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CONSENT FOR GENERAL DENTAL CARE, LOCAL ANETHESIA, AND/OR NITROUS OXIDE/OXYGEN ANALGESIA

Patient Name: _____

You have the right to be informed about your condition and the recommended treatment plan. This informed consent is designed to make you aware of the risks of the treatment plan your dentist has recommended for you.

Risks include, but are not limited to: (please read and initial each item below)

- ___ a) There are risks of anesthesia that may affect you body, such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. Any or all of these may require additional medical management or hospitalization.
- ___ b) Discomfort after dentistry or swelling that may require additional treatment
- ___ c) Infections may require medical or surgical intervention.
- ___ d) Restricted Mouth opening during recovery, sometimes related to muscle soreness at the site if the injection requiring extensive physical therapy.
- ___ e) Local anesthesia may cause prolonged numbness that, in some patients may result in injury from biting or chewing on area (lip, cheek, or tongue) that has received the local anesthetic.
- ___ f) Injury to nerves can result in pain, numbness, tingling, or other sensory disturbances to the chin, lip, cheek, gums, or tongue. This may persist for several weeks, months or rarely, be permanent.
- ___ g) Local anesthesia is administered with a very small fine needle. In very rare instances these needles may break off and be lodges in soft tissue.

The anesthetic that I have chosen for my treatment is:

___ Local anesthesia

___ Local anesthesia with nitrous oxide/oxygen analgesia

___ It has been explained to me, and I fully understand, that a perfect result in any dental procedure is not and cannot be guaranteed.

___ I certify that I can speak, read, and write English and have read and fully understand this consent for local anesthesia and/or nitrous oxide/oxygen analgesia.

PLEASE ASK THE DENTIST OR ANY OF HIS STAFF IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT FORM. DO NOT INITIAL OR SIGN ANY AREA IF YOU HAVE NOT HAD YOUR QUESTIONS ANSWERED.

I hereby acknowledge that I have read this document, have discussed any questions or concerns that I might have regarding my proposed treatment.

Patient Signature

Date

Doctor Signature

Date

Witness

Date