

DENTAL ILLUSIONS
George E. Saliba, DDS
Basil M. Moukarim, DDS
13303 Champions Forest Dr. #5
Houston, TX 77069
(281) 444-1755

Today's Date: _____

I, _____, give my permission to Dr. George E. Saliba and/or Dr. Basil M. Moukarim and the associated in his employ, including hired team members to discuss my health and dental situation/treatments with the following persons:

Name: _____

Address: _____

Contact Numbers:
(work) _____ (home) _____ (cell) _____

Name: _____

Address: _____

Contact Numbers:
(work) _____ (home) _____ (cell) _____

This authorization shall be in effect from this day forward, and until I advise Dr. George E. Saliba and/or Dr. Basil M. Moukarim otherwise in writing.

On this day, _____, I, (print) _____, represent that I am over the age of 18 years, am in sound state and mind, and am competent to enter into this agreement. I am fully aware of and understand the contents of this agreement. All my questions and concerns have been addressed and answered.

Parent's Signature: _____

Date: _____

DENTAL ILLUSIONS

GEORGE SALIBA, D.D.S.
BASIL MOUKARIM, D.D.S.

13303 Champion Forest Dr.
Bldg 5
Houston, TX 77069
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CONSENT FOR SEDATION

I, _____ give consent to receive dental treatment under conscious sedation and do authorize Dr. Moukarim to provide the following services:

I understand that the treatment plan may need to be altered during treatment. I authorize Dr. Moukarim to provide any necessary alternative or additional treatment.

The nature of the dental treatment, the risks and alternatives has been fully explained to me including the risk and alternatives of refusing dental treatment.

All patients undergoing conscious sedation are subject to risk of medical complications including, but not limited to: sore throat, discomfort, bleeding, swelling, nausea and vomiting, allergic reactions, respiratory and cardiovascular problems and death.

I understand that the explanation of the risks and consequences that I have received is not exhaustive and that other less common risks may arise. I have been advised that these less common risks will be explained to me upon request.

Through my signature, I acknowledge that I have read this document in its entirety and that I fully understand it. I have been given the opportunity to discuss this information and have had all of my questions answered. I request and consent to the above treatment.

Patient's Signature

Date

Printed Name

Dental Illusions Anxiolysis Informed Consent Form

- 1) I understand that anxiolysis (defined as the diminution of anxiety) will be achieved by the administration of oral medications and possibly nitrous oxide / oxygen (laughing gas).
 - (1) The anxiolysis appointment will last approximately _____ to _____ hours. I will be given a pill to take upon my arrival to the dental office.
- 2) I understand that the purpose of anxiolysis is to more comfortably receive dental care. Anxiolysis is not required to provide the necessary dental care. I understand that anxiolysis has limitations and risks and success cannot be guaranteed.
- 3) I understand that anxiolysis is a drug-induced state of consciousness to reduce fear and anxiety. I will be able to respond during the procedure. My ability to act and function normally returns when the effects of the sedative wear off.
- 4) I understand and have been informed that the alternatives to anxiolysis are:
 - a) No sedation: The necessary procedure is performed under local anesthetic only.
 - b) Nitrous oxide / oxygen inhalation sedation only. Commonly called laughing gas.
 - c) Oral Conscious Sedation: Sedation using only orally administered sedative medications to achieve a minimally depressed level of consciousness.
 - d) Intravenous (I.V.) Sedation
 - e) General Anesthesia
- 5) I understand that there are risks and limitations to all procedures. For anxiolysis these may include:
 - a) Inadequate initial dosages. This may result in a sub-optimal level of anxiolysis.
 - b) Atypical reaction to the sedative medications. In unusual circumstances this may require emergency medical attention and/or hospitalization. Other atypical reactions may include: altered mental states (e.g. over-sedation or hyper-responding to the sedative medication), allergic reactions, and nausea and/or vomiting.
- 6) I understand that if, during the anxiolysis procedure, a change in treatment is required. I authorize the dentist to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

Designate Person: _____
- 7) I have had the opportunity to discuss anxiolysis and have my questions answered by qualified personnel including the dentist. I also understand that I must follow all the recommended treatments and instructions of my dentist.
- 8) I understand that I must notify the dentist if I am pregnant, or if I am lactating. I must notify the dentist if I have any sensitivity, intolerance, or allergy to any medication. I have informed the dentist of my past and present medical history, if I have recently consumed alcohol or other recreational drugs, and if I am presently on any prescription or non-prescription medications.
- 9) I understand that after taking oral sedatives I am not permitted to drive or operate hazardous machinery for 24 hours after my procedure. I understand and acknowledge that I will have a responsible adult drive me to and from my dental appointment on the day of the anxiolysis procedure.
- 10) By signing below I hereby consent to anxiolysis in conjunction with my dental treatment.

Patient / Guardian
(Signature) _____ (Print) _____

Date _____ Witness _____

DENTAL ILLUSIONS

George Saliba, DDS
Basil Moukarim, DDS

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, check, 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, check, 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