

INFORMED CONSENT FOR IV CONSCIOUS SEDATION DENTISTRY
Michael E. Edenfield, DDS, PC

Patient name: _____

This is my consent for Dr. Michael E. Edenfield or his Associate Dentists, Hygienists, and/or Assistants to provide comprehensive dental care as deemed necessary or advisable under conscious sedation via intravenous, oral or inhalation delivery.

Dr. Edenfield and his Associates have explained to me that there are certain inherent and potential risks in the treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to:

- a) Postoperative discomfort and swelling that may necessitate several days of home recuperation
- b) Bruising and bleeding that may be prolonged
- c) Injury to adjacent teeth and fillings or delayed healing
- d) Postoperative infection requiring additional treatment
- e) Stretching of the corners of the mouth resulting in cracking or bruising
- f) Restricted mouth opening for several days or weeks
- g) Injury to the nerve underlying the teeth resulting in numbness, tingling, burning, or pain of the lips, chin, gums, cheek, teeth and/or the tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently
- h) Inflammation of the vein used for intravenous medication

I agree and understand that the patient has not had anything to eat or drink for FIVE HOURS before the scheduled dental treatment/procedure/surgery.

I give consent to the administration of such local, nitrous oxide, oral and/or intravenous sedation as deemed necessary by the doctor and his/her designated assistants to accomplish the proposed procedure(s).

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of coordination which can be increased by the use of alcohol or other drugs. I have been advised that the patient may not operate any vehicle or hazardous devices or work while taking such medications and/or drugs given to them until they are fully recovered.

I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires an anesthetic. Risks could include pain, swelling, bruising, infection, nerve damage, and unexpected allergic reactions, which could result in heart attack, stroke, brain damage, and/or death.

If any emergency and/or unforeseen condition should arise in the course of the dental treatment/procedure(s) calling for the doctor's judgment, I request and authorize the doctor to perform whatever he/she may deem advisable.

I agree to cooperate completely with the recommendations of the doctor for the above named patient; realizing that any lack of the same could result in a less than optimal result.

The consent granted herein shall remain in full force and effect for so long as the individual (patient named above) is under the care of Dr. Edenfield or Associate Dentists, Hygienists, and/or Associates, unless such consent shall be expressly revoked in writing by the individual(s) in whom the right of consent is designated.

I certify that I have had an opportunity to read and fully understand the terms and words within the above consent to the dental treatment/procedure(s) and the explanation. I also state that I understand English.

Witness

Patient, Parent, Guardian or Conservator

Date