

CONSENT FOR ORAL SEDATION

I, _____, give consent for _____ to receive dental treatment under sedation and do authorize _____ to provide the following services:

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

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

All patients undergoing sedation are subject to the 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 dully 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 for my child.

Patient / Parent / Guardian's Signature

Date