Grant T. King, D.D.S, M.D.S
Mitchel S. Godat, D.D.S., M.S.*
*Board Certified Periodontist and
Dental Implant Surgeon

Periodontal Associates
OF MEMPHIS
Periodontal, Laser and Dental Implant Therapy

Partners Emeritus
Preston D. Miller, Jr., D.D.S.
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Roger D. Craddock, D.D.S.

6268 Poplar Avenue · Memphis, TN 38119 · phone 901.761.3770 · fax 901.761.3775
www.PerioMem.com · Info@PerioMem.com

REQUEST AND CONSENT FOR ANESTHESIA, SEDATION, AND RESTRAINTS

Name_____Date: _____

The following is provided to inform you of the choices, risks and benefits involved with having treatment under anesthesia and/or sedation. This information is presented to enable you to be informed regarding the delivery of sedation during your treatment.

_____ **1**. I, _____, hereby authorize Drs. Craddock, Godat, King and/or Associates, Independent Contractors, Anesthesiologists, or Certified Registered Nurse Anesthetists (CRNA), hereafter referred to as "Sedation Team," to perform the anesthesia and/or sedation procedure previously explained to me, and any other procedure deemed necessary or advisable as an adjunct to the planned sedation procedure. I understand with sedation small doses of various medications will be administered to keep me comfortable and relaxed during treatment. I consent to the administration of such anesthesia/sedation(s) by any route suitable (Local Anesthesia with/without Nitrous Oxide ("Laughing Gas"), with/without Oral Medication ("Pills"), with/without Intramuscular Sedation ("Shot"), with/without Intravenous Sedation ("IV") by the Sedation Team.

_____ **2.** ***Expected Benefits***. The purpose of IV conscious sedation is to lessen the significant and undesirable side effects of long or stressful dental procedures by chemically reducing the fear, apprehension, and emotional stresses sometimes associated with these dental procedures. Additionally, certain medical or physical conditions may necessitate sedation to prevent problems.

_____ **3.** I understand that anesthetics/sedative drugs and physical restraints are necessary to assist the dentist in performing the dental treatment with increased patient comfort and cooperation. I understand the sedation described to me is not general anesthesia and that I will breathe on my own. I also understand I may be very relaxed, may fall asleep, and may not remember part or all of the procedure. No guarantee has been given to me that the proposed treatment will be successful. **If 13 years old or younger, I understand that all sedation medication must be taken in the office.**

_____ **4.** I have been informed and I understand that there are associated *risks* with the use of local anesthetic agents and sedative drugs used to increase patient comfort and to control patient behavior. The risks that occur occasionally include but are not limited to: numbness; inflammation of the veins where drugs are administered; pain, discoloration of tissue surrounding the injection site; bruising; swelling; infection; bleeding; nausea; vomiting; and allergic reactions.

_____ **5.** I have been informed and I understand that in rare instances, the *risks* of sedative drugs include but are not limited to: breathing difficulties; brain damage; stroke; heart attack; or loss of function of any limb or body organ. I understand that severe complications may require hospitalization and may even result in death.

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_____ **6.** The purpose and possible complications to the use of sedative drugs have been explained to me as well as possible alternative methods (listed in #1 above) and their advantages and disadvantages. I understand the purpose, possible risks, and probable effectiveness of each method or approach to treatment as well as the probable result if no treatment is provided.

_____ **7.** I have been advised that good results are expected and that the possibility and exact nature of complications cannot be accurately predicted. I acknowledge that no implied or expressed guarantees as to the result of the treatment or use of anesthetic or sedative drugs have been given to me.

_____ **8.** I acknowledge that I have received written preoperative and postoperative instructions regarding the use of sedative drugs, that these instructions have been explained to me, and that I understand this information and will read and follow the instructions.

_____**9.** As a routine part of the pre-treatment physical exam and testing, all women of childbearing age are asked about their pregnancy status, breast feeding, and last menstrual period. I understand that anesthetics, sedatives, medications, and other drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing the Sedation Team of a possible, suspected, or confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia/sedation. For the same reasons, I understand that I must inform the Sedation Team if I am a nursing mother as many days as possible prior to the procedure I have chosen. If I choose an in-office pregnancy test, I understand a fee covering the pregnancy test will be added to my treatment fee. Women who deny pregnancy will be asked to sign the waiver below. If unsure of pregnancy status or if desired, a urine pregnancy test can be offered to you. All patients however, for reasons of privacy or otherwise, may refuse to have this pregnancy test performed. We also ask that you be truthful in answering questions that your Sedation Team will ask of you regarding time of last period, sexual activity, etc. If you have any questions, please ask the Sedation Team prior to your treatment. Our goal is provide the safest, highest quality of medical care to our patients.

Please choose one of the following options for women of child bearing age:

_____ **Pre-Treatment Pregnancy Test at Home:** I choose to take a pregnancy test at home within five (5) days of my scheduled treatment.

_____ **Pre-Treatment Pregnancy Test at Our Office:** I choose to take a pregnancy test at Periodontal Associates of Memphis five (5) days prior to my scheduled treatment.

_____ **Pregnancy Test Waiver:** I certify that the risks of surgery and anesthesia while pregnant have been explained to me and I am not pregnant. If the chance of pregnancy is in question, I have been offered the opportunity to take a pregnancy test and I decline. I hereby release the Sedation Team of any liability if I am indeed pregnant at the time of this treatment and provision of sedation.

_____ **10.** To help minimize the risks and complications, I have disclosed any abnormalities in my current physical status or past medical history. This includes any history of drug or alcohol abuse and any unusual reactions to medications or anesthetics as well as prior surgeries and sedation.

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_____ **11.** ***Alternatives to Suggested Treatment***. Alternatives to IV conscious sedation include local anesthesia, oral sedation, intramuscular sedation, and general anesthesia in the hospital or surgery center, either as an inpatient or as an outpatient. Local anesthesia and oral sedation may not adequately dispel my fear, anxiety, or stress. If certain medical conditions are present, it may present a greater risk. There may be less control of proper dosage with oral sedation than with IV conscious sedation. General anesthesia will cause me to lose consciousness and generally involves greater risk than IV conscious sedation.

_____ **12.** I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

_____ **13.** I have had the opportunity to ask all of my questions about my anesthesia/sedation and all of my questions have been answered to my satisfaction. I believe I have been given adequate information upon which to base an informed consent. I accept the potential risks, complications, and dangers which may occur with treatment. I read and write English. I have read (or had read to me) this form and fully understand its content and that all blanks were filled in and all inapplicable paragraphs, if any, were crossed out before I signed below.

FINAL SIGNATURE AND CONSENT TO THE ABOVE:

PATIENT OR LEGAL GUARDIAN: _____ DATE: _____

I certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to, the treatment and procedures prescribed for the patient. I have offered to answer any questions and have fully answered such questions. I believe the patient/relative/guardian understands what I have explained and has consented to the proposed treatment and procedures.

DOCTOR: _____ DATE: _____

I hereby certify that the patient/relative/guardian either: has acknowledged in my presence that he/she has received an explanation of, and alternatives to, the proposed dental treatment/procedures, usual and most frequent risks and hazards of, and alternatives to the proposed treatment/procedures, has had all of his/her questions answered, has given his/her consent, and has signed this form where indicated; or after the informed consent discussion and signatures above, has answered "yes" to the proposed treatment.

WITNESS CERTIFICATION:_____ DATE: _____

ALL CONSENT FORMS SHOULD BE SIGNED AND RETURNED OR FAXED TO OUR OFFICE FIVE (5) DAYS PRIOR TO TREATMENT OR YOUR APPOINTMENT MAY BE CANCELLED. FAX: 901.761.3775

Active Member
American Academy of Periodontology
Specialist in Periodontics

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