

**INFORMATIONAL INFORMED CONSENT
ORAL (ENTERAL) SEDATION**

ORAL OR ENTERAL SEDATION is made available by this office to assist in minimizing anxiety that may be associated with going to the dentist. The intent of oral sedatives is to relax you yet still enable you to communicate with the dentist while treatment is being performed. Even though oral sedation is safe, effective and generally free of complications, by reading and signing this form, you acknowledge that you are aware of possible risks of oral sedation, acknowledge these risks, and consent to and accept the option of receiving oral sedation.

1. **I acknowledge that I have read and signed this Informational Informed Consent form** prior to my taking any form of oral sedation. I acknowledge that some oral sedatives are generally prescribed as sleeping pills but are safely used in conjunction with dental procedures to decrease anxiety.
2. **I agree not to drive to or from the office after taking any sedative medication**, and I understand that I am responsible for arranging for my own transportation to and from the dental office. I also agree not to drive or operate any machinery for the remainder of the day of treatment. I agree to have someone stay with me for several hours after sedation due to possible disorientation and to prevent possible injury from falling due to disorientation, loss of balance, etc.
3. **I agree to inform the office and refrain from undergoing oral sedation if the following conditions are present:**
 - A. Hypersensitivity to benzodiazepine drugs (Valium, Ativan, Versed)
 - B. Pregnant or nursing
 - C. Liver or kidney disease.
4. **I have disclosed to the dentist that I am taking any of the following drugs** that may adversely react with oral sedatives: Nefazodone (Serzone); cimetidine (tagamet, tagamet HB, Novocimetine, Peptol); levodopa (Dopar or Larodopa) for Parkinson's Disease; antihistamines such as Benedryl or Tavist); verapamil (Calan); diltiazem (Cardizem); Erythromycin and theazole antimycotic class of drugs (Biaxin, Nizoral or Sporanox); HIV treatment drugs (indinavir and nelfinavar; alcohol; any recreational/illegal drugs.
5. **Side effects** may include light-headedness, headache, dizziness, visual disturbances, amnesia, nausea or allergic reactions. Rarely, these side effects may require medical attention or hospitalization. With some patients, especially smokers, oral sedatives do not provide the desired anti-anxiety effects; therefore, planned dental procedures may need to be postponed or terminated.
6. **Complications may ensue if instructions** of not eating or drinking for a specified interval prior to the dental appointment are not followed.
7. **The onset of many oral sedatives is usually 15 to 30 minutes** and the peak effect generally occurs between one and two hours. Effects of the drug are generally almost completely diminished after six to eight hours. In extreme cases, some patients sustain substantial or severe respiratory depression or the need for hospitalization and in very rare cases, possible cardiac arrest or death. Therefore, it is essential to notify the dentist immediately of any untoward reactions or delayed recovery following the procedure.
8. **I consent to the use of nitrous oxide (laughing gas) in conjunction with oral sedation** as well as local anesthetic.
9. **I authorize the dentist to use his/her best judgment in managing unforeseen conditions** which might unexpectedly arise during the course of oral sedation and the planned dental procedures. I acknowledge that lack of cooperation with recommendations made concerning dosage and other protocols associated with oral sedation may contribute to less than desired results.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of oral or enteral sedation and have received answers to my satisfaction. I acknowledge that oral sedation is an option and not absolutely necessary for dental treatment but, nevertheless, I accept this option. I do voluntarily assume any and all possible risks including, but not necessarily limited to those listed above, including risk or substantial harm or even death, which may be associated with oral sedative drugs. I acknowledge that planned treatment may be postponed or terminated if oral sedative drugs do not provide the desired effect, and I acknowledge that no guarantees or promises have been made to me concerning the efficacy of oral sedation in my case or the case of my minor child or ward for whom I give consent for this procedure. The fees for oral sedation have been explained to me and are satisfactory. By signing this document I am freely giving my consent to allow and auth_____ and/or his/her associates or agents to render oral sedation as deemed appropriate and/or advisable to my dental condition, including prescribing and administering appropriate anesthetics and/or medications.

Patient Name (please print)

Signature of patient, legal guardian,
or authorized representative

Date

Witness to signature

Date