WICHITA FALLS ENDODONTICS

Ben Baker, D.D.S., M.S.
1804 Brook Avenue
Wichita Falls, TX 76301
Phone: 940-247-0286
Fax: 940-228-4148
info@WichitaFallsEndo.com
www.WichitaFallsEndo.com

Oral Conscious Sedation Informed Consent

Oral Conscious sedation utilizes the elective administration of oral sedative medication during dental procedures to reduce the fear and anxiety related to the experience.

The purpose of this document is to ensure that you understand oral conscious sedation and consent to its use during your dental treatment. **Please read each item carefully and initial next to the number**. Your initial and signature is acknowledgement that you have had the opportunity to discuss your questions and concerns, if any, they have been answered to your satisfaction.

___1. I understand that the purpose of oral conscious sedation is to more comfortably receive necessary dental treatment and that it has limitations and risks, and its absolute success cannot be guaranteed.

___2. I understand that oral conscious sedation is a drug induced state of reduced awareness and may decrease my ability to respond. The sedative will not put me to sleep and I will be capable of responding during the procedure. My ability to respond normally will return when the effects of the sedative wear off.

___3. I understand that the sedative prescribed will be a pill that I will take approximately 60 minutes before my scheduled appointment. The effects of this sedative will last approximately 4 hours.

___4. I understand that the alternatives to oral conscious sedation are:

a. No sedation: Treatment is performed using local anesthetic, or not, and the patient is fully aware of surrounding activity.
b. Anxiolytics: A sedative pill is taken prior to treatment to reduce anxiety and fear.
c. Nitrous Oxide sedation: Provides relaxation through inhalation of the gas, and the patient is still generally aware of surrounding activity. Its effects are rapidly reversed with the administration of oxygen (Not offered at this office).
d. Intravenous sedation: The slow injection or drip of a sedative into a vein (Not offered at this office).
e. General anesthetic: Generally used in a hospital setting, it requires breathing to be supported and the patient has no awareness of his surroundings (Not offered by this office).

___5. I have been informed that there are risks and limitations to all dental procedures.

a. Inadequate sedation with the initial dosage which may require undergoing the procedure without full sedation, or having to reschedule the procedure.
b. Atypical reaction to the sedative drug which may require emergency medical attention and/ or hospitalization such as, but not limited to: altered mental state, adverse physical reaction, allergic reaction or other unforeseen sicknesses.
c. The inability to discuss treatment options during the procedure should the circumstance arise, that requires the dentist to change the treatment plan.

___6. If, in the professional judgement of the attending dentist, a change in treatment is indicated, I authorize him to proceed with it. I also understand that I have the right to designate another individual to discuss any changes of treatment with the dentist.

___7. I authorize_____Dr. Ben Baker, or _____ to make the decision on my behalf to change my treatment plan as advised by the attending dentist.

___9. I understand and agree to follow all of the instructions given to me.

___10. I have informed the attending dentist of and/or agree to the following

a. I am not pregnant or breast feeding.
b. I have disclosed all medications and supplements that I currently take.
c. I have disclosed any known allergies.
d. I am of sound mental and physical ability to make the decision to use oral conscious sedation, and I understand what it is and what it is not.
e. I will not consume alcohol within 24 hours of using oral conscious sedation.
f. **I have made arrangements for transportation to and from my scheduled appointment by a trusted person. I understand it is advised this person stay with me for several hours following the appointment to ensure there are no complications due to the medication.**
g. I understand a side effect of this medication that some individuals experience is memory loss for the time during which the medication is being metabolized by the body.

I consent to the use of oral conscious sedation to be used in conjunction with my dental treatment.

_____ _____

Patient or Guardian Signature Date

_____

Witness