VIVA DENTAL

ORAL SEDATION DENTISTRY

Pre-Treatment Instructions

1) NO FOOD for 6 hours prior to your appointment. Exceptions include:
    - For any medications you take on a regular basis
    - If you have a medical reason to eat (ex. diabetic)

2) Clear fluids (such as water or Gatorade) can be taken up to 2 hours prior to your appointment

3) NO ALCOHOL 24 hours prior to appointment

4) NO STIMULANTS (ex. caffeine, nicotine) for 12 hours prior to appointment

5) Avoid eating grapefruit and/or drinking grapefruit juice for 3 days prior to and 2 days after your appointment

6) Wear comfortable clothing
    - Ex. sweatpants and sweatshirt
    - No high heels, etc.

7) Leave all valuables (purse, wallet, watches, phone, etc.) at home or with your companion

8) No contact lenses

9) You must have a responsible companion drive you to and from your sedation appointment
    - You companion will receive instructions at the appointment for continued care, so please have them visit with the dental team when dropping you off for your appointment

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Post-Treatment Instructions for Companion and Patient

1) Patient cannot drive or operate any hazardous equipment for 24 hours
2) A responsible person should be with the patient until they have fully recovered from the effects of the sedation
3) Patient should not go up/downstairs until they have fully recovered
4) Always hold the patients arm when walking as they may have problems with balance while under the effect of the sedation medication
5) Patient should resume normal eating and drinking after sedation appointment
6) Patient should drink plenty of fluids as soon as possible to prevent dehydration and “hangover effect” of the sedation medication
7) Patient may seem alert OR sleepy when they leave. Attend to both the same – do not leave the patient alone.

Please contact us if you have any questions or difficulties. If you feel that your symptoms warrant a physician and you are unable to reach us, go to the emergency room immediately.

Patient / Guardian Print Name	**Patient / Guardian Signature**	**Date**
Companion Print Name	**Companion Signature**	**Date**

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Informational Informed Consent

Oral sedation is made available by this office to assist in minimizing anxiety that may be associated with dental procedures. The intent of oral sedatives is to relax you yet still enable you to communicate with the dentist while treatment is being performed. By reading and signing this form you acknowledge the following:

1) I understand that the purpose of oral sedation is to reduce fear and anxiety associated with dental treatment. I am aware that oral sedation is not required to provide the necessary dental care.
2) I understand that oral sedation is a drug-induced state of reduced awareness and decreased ability to respond. I will be able to respond during the procedure. My ability to respond normally will return when the effects of the sedative wear off.
3) I understand that there are risks and/or limitations to all procedures. For oral sedation these include:
    - Inadequate initial dosage which may require the patient to undergo the procedure without anxiolysis or delay the procedure for another time
    - Atypical reaction to drugs which may require emergency medical attention and/or hospitalization (such as altered mental states, allergic reactions, and physical reactions including possible respiratory depression)
    - Inability to discuss treatment options with the doctor should circumstance requires a change in treatment plan
4) If during the procedure a change in treatment is required, I authorize the doctor to use their professional judgement to make changes they deem necessary for my overall health. I understand that if the changes exceed any given estimate and/or dental insurance I am financially responsible to my dentist for the entire cost of treatment. I understand that I have the right to designate an individual who can speak on my behalf. Such person will remain in the office for the duration of the procedure.
5) I agree to inform the office and refrain from undergoing oral sedation if the following conditions are present:
    - Hypersensitivity to Benzodiazepine drugs (Valium, Ativan, Versed, etc.)
    - Pregnant and/or lactating
    - Liver or kidney disease
6) I agree not to drive to or from the dental office or operate any hazardous equipment for 24 hours after my procedure. I understand that I am responsible for arranging my own transportation to and from the dental office.

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7) I have disclosed to the dentist if I am taking any of the following medications 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 Benadryl or Tavist), Verapamil (Calan), Diltiazem (Carizem), Erythromycin and the Azol antimycotics (Biaxin, Nizoral, or Sporanox), herbal medication, HIV treatment drugs (Indinavir, Nelfinavir), alcohol, and recreational/illicit drugs.
8) I authorize the utilization of emergency resuscitative measures and all necessary measures to maintain the airway, and transfer to another facility as needed for any advanced level of care.
9) I acknowledge that I have read and signed this Information Informed Consent form prior to my taking any form of oral sedation.

I have been given the opportunity to ask any questions regarding the nature and purpose of oral sedation and have received answers to my satisfaction. I acknowledge that oral sedation is an option and not necessary for dental treatment, but nevertheless, I accept this option. I do voluntarily assume all possible risks including but not limited to those listed above. 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 bene made to me concerning the efficacy of oral sedation. The fees for oral sedation have been explained to me satisfactory. By signing this document, I am freely giving my consent to allow and authorize the dentist and their dental assistants to render oral sedation as deemed appropriate and/or advised to my dental conditions, including prescribing, and administering appropriate local anesthetics and/or medications.

Patient / Guardian Print Name	**Patient / Guardian Signature**	**Date**
Witness Print Name	**Witness Signature**	**Date**
Dentist Print Name	**Dentist Signature**	**Date**