# ANESTHESIA FOR DENTAL TREATMENT

*Patient's Initials*

_____ The details of the procedure, including the anticipated benefits and material risks, have been explained to me in terms I understand.

_____ My mouth has been carefully examined. Alternative methods and therapies and their benefits, material risks, and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of anesthesia are not limited to those shown below:

| Anesthesia Type | Expected Results | Technique | Risks |
|---|---|---|---|
| __ *General anesthesia* | *Total unconscious state, possible placement of breathing tube into windpipe* | *Drug injected into bloodstream, breathed into lungs, or by other routes* | *Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, or aspiration* |
| __ *Local anesthesia* | *Temporary loss of feeling and/or movement of specific area* | *Drug injected near nerves, providing loss of sensation to the area of operation* | *Infection, convulsions, weakness, persistent numbness, residual pain, or injury to blood vessels* |
| **Sedation Type** | **Expected Results** | **Technique** | **Risks** |
| __ *Deep sedation* | *A very deep type of sedation that may require you to have assistance with your breathing* | *Medication taken by mouth, breathed into the lungs, or injected into the bloodstream* | *Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, or aspiration* |
| __ *Moderate sedation* | *Sedation that suppresses some memories of the procedure; you will breathe on your own and respond to verbal commands* | *Medication taken by mouth, breathed into the lungs, or injected into the bloodstream* | *Allergic reaction to medication or injury to blood vessel at injection site; possibility of becoming deeply sedated* |
| __ *Conscious sedation* | *Sedation that is very relaxing yet allows you to breathe on your own and respond to verbal commands* | *Medication taken by mouth, breathed into the lungs, or injected into the bloodstream* | *Allergic reaction to medication or injury to blood vessel at injection site* |
| __ *Minimal sedation (anxiety relief)* | *Relief of anxiety before and during the procedure; you remain awake and aware of your surroundings* | *Oral medication taken before or after arriving at the facility* | *Minimal risk associated with this technique; occasional drowsiness* |

_____ I understand that if nothing is done, any of the following could occur: loss of bone, gum tissue inflammation, or infection, sensitivity, looseness, or drifting of teeth followed by necessity of extraction. Also possible are temporomandibular joint (TMJ) problems.

_____ I understand and accept that complications, including the remote risk of death or serious disability, exist with any surgical procedure.

_____ I fully understand that during and following the contemplated dental procedure, oral surgery, or treatment, conditions may become apparent that warrant, in the judgment of my dentist/oral surgeon, additional or alternative treatment pertinent to a successful outcome. I also approve any modifications in design, materials, or care if it is felt by my dentist/oral surgeon to be in my best interest.

_____ I understand that tissue cannot heal without scarring and that how a scar heals depends on individual genetic characteristics. The dentist/oral surgeon will do his/her best to minimize scarring but cannot control its ultimate appearance (if applicable).

_____ I am aware that occasionally speech can be affected by oral surgery/dental procedures. I am aware that further soft tissue surgery is sometimes necessary to improve the final outcome.

_____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications (if applicable).

_____ I understand that excessive smoking or use of alcohol or sugar may affect gum healing and may limit the success of my procedure. I agree to follow my doctor's home care instructions and report to my dentist for regular examinations as instructed.

_____I understand that oral hygiene is critical to the future success of my treatment plan and that I must maintain good oral hygiene. Like normal dentition, the desired outcome of this procedure may be affected by lack of oral hygiene and can actually be lost due to neglect.

_____I have informed the dentist of all my known allergies.

_____I have informed the dentist of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any recreational drug or alcohol use.

_____I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

_____To my knowledge, I have given an accurate report of my physical and mental health history, including any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, or dust, and any abnormal bleeding or other condition.

_____I am aware and accept that no guarantees about the results of the procedure have been made.

_____I have been advised of the probable consequences of declining recommended or alternative therapies.

_____I have been informed of what to expect postoperatively, including but not limited to, estimated recovery time, anticipated activity level, and the possibility of additional procedures.

_____I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation (if applicable).

_____Pre- and postoperative photos and/or videos may be taken of the treatment for record purposes. I understand that these photos and/or videos will be the property of the attending dentist/oral surgeon (if applicable).

_____ I request and authorize dental services, including anesthesia.

_____I agree to the type of anesthesia—local or general—administered intravenously, intramuscularly, orally, or by inhalation. I agree not to operate a motor vehicle or machinery for at least 24 hours (or more) until I am fully recovered from the effects of anesthesia or medications given for my care. I am aware that possible anesthesia risks include inflammation of veins and allergic reactions caused by my medications.

_____ I am satisfied that the dentist/oral surgeon has answered all of my questions regarding this procedure and that I understand all the terms of this agreement.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, DDS/DMD/MD, with associates or assistants of his or
(*Dentist/Oral Surgeon Name)*
her choice, to perform the procedure of _____ on
(*Procedure Name)*
_____ at _____.
*(Patient Name)* *(Facility Name)*

I further authorize the dentist(s)/oral surgeon(s) and any assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

_____ _____
*Patient or Legal Representative Signature/Date/Time* *Relationship to Patient*

_____ _____
*Print Patient or Legal Representative Name* *Witness Signature/Date/Time*

I certify that I have explained the nature, purpose, anticipated benefits, material risks, possible complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding, to the patient or the patient's legal representative. I have answered all questions fully, and I believe the patient/legal representative (circle one) fully understands what I have explained.

_____
*Dentist/Oral Surgeon Signature/Date/Time*

_____ Copy given to patient _____ Original placed in patient's chart
*Initials* *Initials*