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INFORMED CONSENT FOR DENTAL TREATMENT AND ANESTHESIA/SEDATION

This is my consent for Dr. Milnes/Dr. Farquhar to perform the following treatment/procedure/surgery:

_____

as previously explained to me or other procedures deemed necessary or advisable as necessary to complete the planned treatment.

Conscious sedation has been advised for the comfort and well being of my child during dental treatment. The sedation/management fee for this appointment is $_____. Since this appointment will require the undivided attention of the dental staff during my child's dental treatment, no other patient's treatment will be scheduled during this time period. Therefore, I agree to pay the sedation fee in advance of treatment to secure the appointment time and ensure my cooperation in following pre-sedation instructions and prompt attendance at the scheduled appointment. If the sedation appointment is failed or 48 hours notice is not given prior to the sedation appointment or if my child eats prior to the appointment, the total sedation/management fee will be applied as a broken appointment fee. Another sedation/management fee totaling $_____ will be due prior to making another appointment

I understand that the purpose of this treatment/procedure/surgery is to treat and possibly correct diseased oral/maxillofacial tissues. Without treatment this condition will persist and my child's present oral condition can worsen with time, and the risks to my child's health include, but are not limited to, the following: swelling, pain, infection, cyst formation, periodontal (gum) disease, dental abscess, malocclusion, loss of teeth, and/or premature loss of bone. I have been informed of possible alternate methods of treatment.

Dr. Milnes/Dr. Farquhar has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance, such operative risks include, but are not limited to:

Pain and swelling at the IV Site with/without discoloration.
Dizziness, disorientation and/or lack of coordination as a result of the sedative medication(s)
Hallucinations and /or mood swings
Postoperative nausea or vomiting
Postoperative discomfort**,** prolonged bleeding, and swelling that may necessitate several days of home recuperation**.**
Postoperative infection requiring additional treatment.
Injury to other teeth and/or fillings.
Stretching of the corners of the mouth with resultant cracking and bruising.
Decision to leave a small piece of root in the jaw, sinus or tissues when its removal would require extensive surgery.
Other:_____

It has been explained to me that, during the course of the procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those explained to me. If such unforeseen condition(s) should arise in the course of the procedure, calling for Dr. Milnes/Dr. Farquhar judgement or for procedure(s) in addition to or different from those now contemplated, I request and authorize Dr. Milnes/Dr. Farquhar and staff to do whatever they may deem advisable.

No guarantee or assurance has been given to me that the proposed treatment will be curative or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective retreatment, or worsening of my child's present condition despite the care provided. However, it is Dr. Milnes/Dr. Farquhar opinion that therapy would be helpful, and that a worsening of my child's condition may occur sooner without the recommended treatment.

I consent to the administration of anesthesia, including local anesthesia, nitrous oxide/oxygen (laughing gas), oral sedation and/or intravenous sedation in connection with the procedure(s) referred to above and to the use of such anesthetics as may be deemed advisable with the exception of:

_____ to which my child is allergic.

(none or name of particular drug or anesthetic)

Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of other drugs. I have been advised to supervise my child following the dental procedure/sedation for at least twenty-four (24) hours after his/her release from the dental office or until further recovered from the effects of the anesthetic medication and drugs that may have been given to my child in the office for his/her care. I agree not to use public transit to take my child home and to accompany my child after discharge from the dental office in my private automobile or in a taxicab.

I have informed Dr. Milnes/Dr. Farquhar of my child's past medical and health history including serious problems, injuries and/or previous operations and anesthetics.

I understand and agree that my child has not had anything to eat or drink prior to surgery as specified in the preoperative feeding instructions which were given to me in writing by the office staff.

I agree to cooperate completely with the recommendations of Dr. Milnes/Dr. Farquhar while my child is under his care, realizing that any lack of same could result in a less than optimal result.

I certify that I have had an opportunity to read and fully understand the terms within the above and consent to the procedure(s) and the explanation referred to or made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed. I also state that I read and write English.

Patient:_____Parent/Guardian:_____

Staff:_____Date:_____