Oral Sedation Informed Consent

Authorization: I, ______________________________, parent, legal guardian, or person with authority to consent for _________________________________ authorize Dr. Diaz to perform the following operation or procedure(s), in part or in sum as discussed in the treatment planning of care of my child by Dr. Diaz.

Reason: I understand the reason(s) for the procedure(s) to be done under sedation is related to one or more of the following: Extent of treatment needed, young age, situational anxiety, or medical history.

Alternative: Alternatives to this procedure have been fully discussed with me by Dr. Diaz and include no treatment, protective stabilization alone, local anesthesia alone, local anesthesia in combination with protective stabilization, IV sedation with anesthesiologist in office, or general anesthesia in hospital setting.

Risks: I give authorization with the understanding that any procedure may involve certain risks or hazards. **I understand that the risks of the procedure(s) include, but are not limited to infection, bleeding, nerve injury, blood clots, allergic reactions, soreness of the mouth, lips, gums, and teeth, numbness, fever, nausea, and vomiting. I understand that sedation risks include, but are not limited to infection, bleeding, nerve injury, blood clots, allergic reactions, pneumonia, aspiration, soreness of the mouth and nose, numbness, fever, nausea, vomiting, altered heart and breathing rate, brain damage, or death.** These risks may imply serious, possible fatal, consequences.

Additional Procedures: If Dr. Diaz discovers a different unsuspected condition at the time of surgery, I authorize her to perform such operation or procedure that she deems necessary.

Guarantee: I understand that no guarantee or assurance has been made as to the ultimate result of the procedure.

Parental Consent: I have read and fully understand this consent form. I understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the words contained in this form.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED OPERATION OR PROCEDURE OR ANY OTHER QUESTIONS CONCERNING THE PROPOSED PROCEDURE, ASK DR. DIAZ NOW BEFORE SIGNING THIS CONSENT FORM.

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Parent, Guardian, or person with authority to consent for patient   Date   Time

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Relationship to Patient   Witness to Signature