ARIZONA NESTHESIA FOR DENTISTRY

INFORMED CONSENT for ANESTHESIA

Patient Name:_____ Patient Date of Birth:_____

The following is provided to inform patients, and/or parents/guardians of minor children of the choices and risks involved with having dental treatment under anesthesia. This information is not presented to make patients, parents or legal guardians more apprehensive but to enable them to be better informed concerning their treatment. ***Initials:***_____

The most frequent side effects of any anesthesia are drowsiness, nausea/ vomiting and phlebitis. Most patients remain drowsy or sleepy following their surgery for the remainder of the day. As a result, coordination and judgment will be impaired for as long as 24 hours. It is crucial that adults refrain from activities such as driving, and children remain in the presence of a responsible adult during this period. ***Initials:***_____

I understand that on rare occasions anesthesia related complications include but are not limited to: pain, hematoma, numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reaction and pneumonia. I further acknowledge understand and accept the extremely remote possibility that complications may require hospitalization and/or result in brain damage, stroke, malignant hyperthermia, heart attack, or death. I have been made aware that the risks associated with local anesthesia, conscious sedation and general anesthesia vary. Of the three choices of anesthesia local anesthesia is usually considered to have least risk and genera! Anesthesia the greatest risk. ***Initials:***_____

I consent, authorize and request the administration of such anesthetic(s) by any route that is deemed suitable by the anesthesiologist, who is an independent contractor and consultant. It is the understanding of the undersigned that the anesthesiologist will have full charge of the administration of the anesthesia and this is an independent function from the surgery/dentistry. Furthermore, it is understood that the anesthesiologist assumes no liability from the surgery/dentistry performed while under anesthesia and that the dentist assumes no liability for the anesthesia. ***Initials:***_____

I understand Arizona Anesthesia for Dentistry will safeguard my health information based on the rights given to me under the Health lnsurance Portability and Accountability Act (HIPAA). ***Signature:***_____

Females: I understand that anesthesia may be harmful to the unborn child and may cause birth defects or spontaneous abortions. I accept full responsibility for informing the anesthesiologist of the possibility of being pregnant, a confirmed pregnancy, and/or being a nursing mother). ***Signature:***_____

I have been made fully aware and completely understand the alternative to general anesthesia. I accept the possible risks, side effects, complications and consequences of anesthesia. I acknowledge the receipt of and understand both preoperative and post-operative instructions. It has been explained to me and I understand that there is no warranty and no guarantee as to any result. I have had the opportunity to ask questions about my or my child's anesthesia and I am satisfied with the information provided to me. It is also understood that the anesthesia services are completely independent from the operating dentist's procedure.

Please print name:_____ Relationship:_____

Patient/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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