Park Family Dental

Consent for IV Sedation

Patients Name: _____ Date of Birth _____

This is my consent for Dr. Roh to perform the following treatment/procedure/surgery under IV sedation:

_____

Please Initial next to each item below:

- _____ I consent to administration of local/general anesthesia for Dr. Roh to accomplish the procedure proposed above.
- _____ I certify that I have not had anything to eat or drink in the last 8 hours, including water.
- _____ I certify that I have not taken any street drugs or non-prescribed medication in the last 24 hours, including but not limited to cocaine, heroin, and marijuana. I realize that by not revealing this information, I place myself under significant risk.
- _____ I understand that medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness/ coordination, which can be increased by the use of alcohol or other drugs. I understand that certain risks, which could involve serious bodily injury, are inherent in any procedure that requires general anesthesia and/or prescription pain medication.
- _____ I understand and agree not to operate any vehicle or machinery for at least 24 hours after my release from surgery or until further recovered from the effects of the anesthetic medication that has been given to me in the office. I understand that I am advised not to operate any vehicle, automobile, hazardous devices, or work while taking prescribed medications and/or drugs; or until fully recovered from the effects of same.
- _____ I agree not to drive myself home after surgery. I have a responsible adult with me that will drive me home today.
- _____ If any unforeseen condition should arise during my procedure, calling for Dr. Roh's judgement or for procedures in addition to or different from those now contemplated, I request and authorize Dr. Roh to do whatever he may deem advisable. This includes waking me up before the procedure is finished if at any time the conditions become unsafe or risky to my health.
- _____ I certify that I have had an opportunity to discuss with Dr. Roh my past medical/health history, including any/all medications I am taking and any serious health problems and/or injuries. I am not withholding any information.
- _____ I agree to cooperate completely with the recommendations of Dr. Roh while I am under his care, realizing that failure to do so may result in a less than optimum result.

I have read and discussed the preceding with the doctor and believe I have been given sufficient information to give my consent to the planned procedure under IV sedation. It has been explained to me, and I understand that success of the aforesaid surgical procedure(s) and treatment is not guaranteed or warranted. No warranty or guarantee has been made as to the results or cure. I certify that I speak, read, and write English and have read and fully understand this consent form for surgery; or if do not, I have had someone translate so that I can understand the consent form. All blanks were filled in prior to my initials and signature. I have been given the opportunity to question the above complications and understand.

_____ _____ _____

Patient's (or legal guardian's) signature **Relationship to Patient** **Date**

_____ _____

Witness signature Doctor's signature