

Nicholas A. White, DMD

INFORMED CONSENT FOR IV CONSCIOUS SEDATION FOR DENTAL TREATMENT

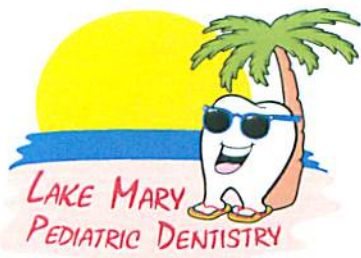
Patient's Name _____

Date of Birth _____

Our objective in caring for your child is the same as yours. We want to restore child's mouth to a state of good dental health and keep him or her as comfortable as possible in the process. Children who are very young (pre-cooperative), very anxious, uncooperative, or require extensive dentistry requiring multiple appointments benefit from sedation. This type of sedation is not the same as general anesthesia used in hospital operating rooms. Rather, it is a controlled sleep that insulates the child from the stimulation of dental treatment while allowing the dentist to complete treatment in a safe and efficient manner. The MEDICALLY REASONABLE ALTERNATIVE options are: General anesthesia or no treatment.

Your child will be lightly asleep and there is the possibility of small bodily movements. Occasionally, it may be necessary to place your child in a medical immobilization blanket (papoose board). The type of sedative drugs and technique will be determined by the anesthesiologist, Dr. David Schultz, who will evaluate the medical history, length of the procedure, and body weight of your child.

I hereby authorize Dr. Nicholas White to perform necessary dental treatment, including but not limited to, fillings, nerve treatments, crowns extractions, and x-rays on my child/legal ward utilizing sedation techniques performed by the anesthesiologist Dr. David Schultz. I understand that my child is unable to be treated in a cooperative patient- doctor setting using usual and customary dental techniques, or the necessary procedures require the use of sedation in order for completion. The purpose and nature of the need for sedation has been fully explained to me.



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I fully understand there is a possibility of surgical and or medical complications developing during or after the procedure. These risks and side effects may include swelling, pain, bleeding, infection, damage to adjacent teeth, adverse drug reactions, or atypical psychological response that may even cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage, or death. I further authorize Dr. David Schultz and/or Dr. Nicholas White to perform treatment as may be advisable to preserve the health and life of my child/legal ward.

I understand that sedation may prove partially or completely ineffective in managing my child/legal ward. In such an instance, the planned treatment may not be possible or may require several appointments using these sedation techniques to complete the necessary dental work and/or an alternative treatment may be instituted.

I have been provided with an explanation of alternatives to treatment and understand the risks of not being treated for the dental condition. I have carefully read the above and in addition have had all of my questions in regard to sedation to be administered, the outlined risks, and side effects answered.

I do give my free and voluntary informed consent to the same.

Signature _____ Relationship _____

Date _____

Witness _____

Doctor _____