JAY M. AZLING, D.D.S.
& ASSOCIATES

REQUEST FOR ANESTHESIA AND SEDATION

It is our moral and legal obligation to give you the information necessary to make an educated decision in requesting treatment. The benefits of therapy are usually greater than the risk, but just as there are risks involved with driving a car, there are events that can occur with any type of treatment. These are being explained to inform and educate you...not to alarm you. Eliminating surprises will make your care go more smoothly. As with any dental procedure you must advise us of your medical status including a complete disclosure of all medication and/or drugs that you are currently taking with special notice to us if you are pregnant or have glaucoma _____initial

Routine Aftermath...

(1) Minor oozing of blood from the surgery sites, if you are having teeth pulled, which will require you to use gauze pressure packs for the first 24 to 36 hours.

(2) Postoperative discomfort and swelling which may require several days of home recuperation.

(3) Chapping of the lips caused by stretching the corners of the mouth during surgery.

(4) Stiffness of the jaws and restricted mouth opening from several days to several weeks depending on the extent of the treatment.

(4) Possible temporary amnesia. _____initial

Rare occurrences... can include any event that might be remotely possible but unlikely to occur. People rarely plan their lives around these, but are still aware that they can occur. These include: allergic reaction to drugs which range from hives to heart failure. Many drug reactions are side effects and treated as such.

The office staff has had training in managing these potential problems. _____ initial

**Medication, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and co-ordination, which can be increased by the use of alcohol or other drugs**. It would be wise not to operate any vehicle, automobile or hazardous device while taking such medication and /or drugs. Your judgment and work performance can be altered by pain medication or the sedative agents and you should plan accordingly. Your signature below certifies....

-Your consent and request for Dr. Azling to perform the following treatment, procedure or surgery...

Full treatment as described in my treatment plan _____ initial

-Your understanding that on rare occasions, individual patient differences can result in relapse of a condition in spite of our efforts to provide optimum care. In this event you understand that selective retreatment may be necessary. _____ initial

-Your agreement to the administration of anesthesia, nitrous oxide/oxygen and /or oral sedation as discussed with Dr. Azling or any dentist working with him. _____ initial

-Your authorization for Dr. Azling to use his best judgment in managing unforeseen conditions which might unexpectedly arise during the course of the procedure. _____initial

-Your understanding that lack of cooperation with our recommendation during your care may result in less than optimum result. _____ initial

-That you read and write English, understand the above information and have the opportunity to review and discuss it as well as your health history including any serious problems or injuries.

-That all statements requiring insertion or completion were filled in, and inapplicable paragraphs, if any were stricken before you signed.

-That you are both mentally and physically competent to give this consent. _____ initial

_____ _____

Witness Date Patient, Parent or Guardian Date

_____

Dr. Azling Date

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