

**CONSENT FOR SEDATION PROCEDURES**

I understand that local anesthetics, sedative drugs, and physical restraints are necessary to assist Drs. Moran/Brooks and his associates in performing the charted dental treatment.

I understand that physical restraints are necessary for increased patient comfort, safety, and cooperation.

I understand that there are risks with the use of local anesthetic agents. The risks include, but are not limited to: numbness; discoloration of the tissue surrounding the injection site; swelling; infection; bleeding; nausea; vomiting; and allergic reactions. I understand that severe complications may require hospitalization and may even result in death.

I understand that there are risks with the use of sedative drugs. The risks include but are not limited to: breathing difficulties; brain damage; stroke; heart attack; or loss of function of any limb or body organ. I understand that severe complications may require hospitalization and may even result in death.

Drs. Moran/Brooks have discussed with me to my satisfaction possible treatment complications. I acknowledge the receipt of and understand the preoperative and postoperative instructions.

Possible alternative methods of treatment, their advantages and disadvantages along with probable results if **NO TREATMENT** have also been explained to me.

I have been told that good results are expected but that the possibility and exact nature of complications of dental treatment cannot be accurately predicted. I agree that no implied or expressed guarantees as to the result of the treatment or the use anesthetic or sedative drugs have been given to me.

I request and authorize Drs. Moran/Brooks and/or his associates or assistants of his choice to use local anesthetics, sedative drugs, and physical restraints as deemed appropriate by the judgement of Drs. Moran/Brooks, as previously explained to me, in performing dental treatment for **(Patient Name)** \_\_\_\_\_ with the exceptions of (if none, please note): \_\_\_\_\_

I have had the opportunity to ask all of my questions. All of my questions have been answered to my satisfaction. I confirm that I have read this form or it was read to me. I understand, to my satisfaction, the procedures to be performed and accept the possible risks.

Legally responsible parent/guardian: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to the treatment procedures specified above. I have offered to answer any questions and believe fully answered such questions. I believe the parent/guardian understands what I have explained, and has consented to the proposed procedures as recorded in the dental chart.

Robert Moran DDS, MS: \_\_\_\_\_ Date: \_\_\_\_\_

Richard F. Brooks, DDS: \_\_\_\_\_ Date: \_\_\_\_\_



I hereby certify that the parent/guardian either has acknowledged in my presence that he/she has received an explanation of, and alternatives to, the proposed dental treatment/procedures, usual and most frequent risks and hazards of, and alternatives to the proposed treatment/procedures; has had all of her/his questions answered, and has given his/her consent, and has signed this form where indicated. After the informed consent discussion and signatures above, the parent/guardian has answered "yes" to all of the following questions:

1. Did Dr. Moran or Dr. Brooks explain the treatment and procedures to you?
2. Have all your questions about the treatment and procedures been answered?
3. Is the signature of this child's legal guardian on the consent form?
4. Have you given your consent to the proposed treatment and procedures?

Witness: \_\_\_\_\_

Date: \_\_\_\_\_