

**INFORMED CONSENT FOR DENTAL TREATMENT
USING GENERAL ANESTHESIA**

Name of patient: _____

Name of authorized representative: _____ Relationship: _____

Telephone number(s) of authorized representative: _____

It has been determined that this individual may lack sufficient capacity to make an informed decision regarding the risks, benefits, and alternatives to the proposed treatment. Therefore, it is recommended that substitute consent be obtained from an authorized representative.

1. I authorize James P. Ritter, DDS (dentist) and Rona Nakamoto, MD (anesthesiologist) to use local anesthetics, oral and IV medications, and standard medical immobilization procedures in performing any necessary dental treatment for the individual who I represent. Treatment may include but may not be limited to a dental exam, cleaning, diagnostic x-rays, root canal treatment, fillings, extractions and any oral surgical procedures as recommended. I understand that the anesthetics/sedative drugs and standard medical immobilization procedures are necessary to assist the dentist in performing accurate diagnoses and treatments with increased patient comfort, safety and cooperation.

2. I have been informed and I understand that there are associated risks with dental treatment procedures and the use of local anesthetic agents and sedative drugs used to increase patient comfort and to control patient behavior. Risks which may occur include, but are not limited to numbness, inflammation of the veins used for administering the drugs, discoloration of tissue surrounding the injection site, swelling, infection, bleeding, nausea, vomiting and allergic reactions. I have been informed and I understand that in rare instances, the risks of sedative drugs include but are not limited to: breathing difficulties, brain damage, stroke, heart attack, or loss of functions of any limb or body organ. I understand that severe complications may require hospitalization and may even result in death. Alternatives may be discussed with the anesthesiologist or dentist as desired.

3. I have been advised that good results are expected and that the possibility and exact nature of complications cannot be accurately predicted. I acknowledge that no implied or expressed guarantees as to the result of anesthetic or sedative drugs or specific dental treatments have been given to me. I understand that during the course of the patient's dental treatment, unforeseen conditions may arise that make it necessary for the doctors to perform additional procedures other than those listed above. I authorize the doctors to perform such necessary treatments.

4. I authorize the doctors to preserve for scientific purposes or to dispose of oral tissues/teeth removed during the treatment in accordance with standard practice.

Consent or Refusal to Participate: I have read the above and I understand the potential benefits, risks, and alternatives to dental treatment/general anesthesia. I have been afforded an opportunity to have any questions answered and I understand that consent may be revoked at any time. **My decision regarding this treatment is as follows:**

I/We consent : _____ I/We do not consent: _____

Signature of Authorized Representative: _____ Date: _____

Please contact the SEVTC Dental Office (757-424-8227) with questions/concerns.