

**PARENTAL OR GUARDIAN INFORMED CONSENT FOR  
ROUTINE DENTAL CARE USING GENERAL ANESTHESIA**

1. I request and authorize Drs. James P. Ritter, James J. Bukovac, and Dr. Rona Nakamoto (anesthesiologist) to use local anesthetics, oral and IV medications, and physical restraints in performing dental treatment for: \_\_\_\_\_ (patient's name).
2. I understand that the anesthetics/sedative drugs and physical restraints are necessary to assist the dentist in performing the dental treatment with increased patient comfort and cooperation.
3. I have been informed and I understand that there are associated risks with 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.
4. 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.
5. The purpose and possible complications to the use of sedative drugs have been explained to me as well as possible alternative methods and their advantages and disadvantages. I understand the purpose, possible risks, and probable effectiveness of each method or approach to treatment as well as to the probable result if no treatment is provided.
6. 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 the result of anesthetic or sedative drugs have been given to me.
7. 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.
8. I authorize the dental office to preserve for scientific purposes or to dispose of dental or medical tissues removed during the dental treatment in accordance with medical practice.
9. I acknowledge that I have received written preoperative and postoperative instructions regarding the use of sedative drugs, that these instructions have been explained to me, and that I understand this information. I confirm that the person receiving treatment has not had any solid food for 8 hours prior to the scheduled treatment.
10. I believe that I have been given adequate information upon which to base an informed consent.
11. I confirm that I have read and understand this form, or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were crossed out before I signed below.

\_\_\_\_\_

**I hereby authorize and request Dr. Rona Nakamoto to administer the necessary anesthetics to \_\_\_\_\_ (print name), which in their opinion, may be deemed appropriate for dental procedures to be performed on \_\_\_\_\_ (date). I certify that the nature of the anesthetic procedures, including risks and possible complications, have been explained to me and I understand the purpose of this authorization form.**

**Signature of patient/AR/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Dated: July 2017