



Please initial all lines at the left when you understand and agree with the statement.

Anesthesia consent

___ This is my consent for Pierre J. Tedders, DDS to provide oral or intravenous sedation.

___ I have informed Dr. Tedders of my past medical and health history including serious problems or injuries.

___ I attest that I am not under the influence of alcohol, illicit drugs or recreational marijuana. I have informed Dr. Tedders of any mood-altering prescriptions that my primary care provider has prescribed and the dosage. If Dr. Tedders determines that I am not physically able to undergo sedation due to these circumstances, he has the obligation to cancel my surgery and charge a non-refundable fee of \$500.

___ It has been explained to me that there are certain inherent and potential risks in any treatment plan or procedure, that is this specific instance, such risks include; but are not limited to: Postoperative nausea and/or vomiting, pain, thrombophlebitis (blood clot or clots), arterial puncture, infiltrations (fluid into the tissues), hematomas (bruises), temporary amnesia, laryngospasm, bronchospasm, allergic reactions, hypotension, hypertension, respiratory depression, and irregular heartbeat.

___ I consent to the administration of anesthesia, including local anesthesia, nitrous oxide/oxygen (laughing gas) and or oral or intravenous sedation in connection with the procedure(s) by my dentist of record and to the use of such anesthetics as may be deemed advisable with the exception of:

_____ to which I am allergic.

___ Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs; thus, I have been advised no to operate any vehicle, automobile or hazardous device or at least 24 hours after my release from surgery or until further recovery from the effects of the anesthetic medication and drugs that may have been given or prescribed to me in the office for my care. I agree not to drive myself home after surgery and will have a responsible adult drive and accompany me home after my discharge from surgery.

___ I understand and agree that I am not to have and/or have not had anything to eat or drink for 6 hours.

___ I agree to cooperate completely with the recommendations of Dr. Tedders while I am under his care, realizing that any lack of same could result in a less than optimal result.

___ I certify that I have had an opportunity to and that I fully understand the terms and words within the above consent and the explanation(s) referred to or made, and that all the blanks or statements requiring insertion or completions were filled in and any inapplicable paragraphs, if any, were stricken before I signed. I have had the opportunity to ask questions regarding the procedure(s), risks and benefits and alternative procedures, if any, and all my questions have been answered to my satisfaction.

I also state that I can read and write English, or an interpreter explained this for me, to my satisfaction.

Patient Parent/Guardian (if under 18) Date

Witness/Interpreter Dr. Tedders Date