MARTIN B. SANDERS, DDS
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GENERAL DENTISTRY WITH SEDATION
929 S. MAIN ST. #100
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O:630-620-0929
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NAME:_____

INFORMED CONSENT FOR DENTISTRY WITH SEDATION

1. This is my consent for Dr. Sanders and/or any dentist and assistants working with him to treat the following condition(s)._____
2. The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the procedure to be:
   _____
3. I understand that the purposes of the elective dental procedures are to treat and possibly correct my diseased dental condition. The doctor has advised me that if this condition persists without treatment, my present oral condition will probably worsen with time, and the risks to my health may include, but are not limited to the following: swelling: pain; infection; cyst or abscess formation: periodontal(gum) diseases: dental caries, malocclusion, premature loss of teeth and/or bone. I have been informed of the possible alternative methods of treatment, if any.
4. I further understand that this is an elective procedure and other forms of treatment or no treatment at all are choices that I have.
5. The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that the risks of dental and sedation procedures include, but are not limited to:

A. Post-operative discomfort and swelling that may necessitate several days of home recuperation.

B. Post-operative infection requiring additional treatment.

C. Stretching of the corners of the mouth with resultant cracking, bruising, and sores.

D. If intravenous medication is used, soreness at the injection site or along the vein may develop, as well as discoloration of the injection site and possible vein inflammation.

E. Tempero-mandibular joint (TMJ, jaw joint) and muscle spasm problems can occur after dental procedures which may require additional treatment(s). Earaches and worsening of pre-existing temperomandibular joint problems can occur.

F. I understand that certain anesthetic risks, which could cause serious bodily injury, including cardiac arrest, are inherent in any procedures that require sedation.

G. Sensitivity to hot, cold, and or sweets will normally occur for the first two weeks, and may persist following any dental treatment. In addition, throbbing pain may occur which may or may not persist. Please notify Dr. Sanders if this type of pain persists.

H. The possibility exists that any teeth treated may need future root canal treatment or extraction, with teeth deeply decayed more likely to need such treatment.

I. The possibility of sores in the mouth developing after dental treatment as a normal reaction to the stress and or trauma of dental treatment.

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J. Dr. Sanders and/or his staff have further informed me of the necessity of future recall cleaning and examination appointments in order to minimize future tooth decay or tooth bone support (periodontal) problems.

6. I agree and understand that I am not to have and/or have not had anything to eat or drink for six hours before my treatment if sedation is to be used.

7. I consent to the administration of sedation, including local anesthesia in connection with the procedure(s) referred to above, and to the use of such anesthetics as may be deemed advisable by Dr. Sanders, his associates or assistants.

8. I consent to allow Dr. Sanders to tract any additional decay found with restorations and to further treat any deep areas of decay with necessary root canal or extractions at his discretion while under the influence of sedation.

9. Medication, 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 not to operate any vehicle, automobile or hazardous devices, or work, while taking such medications and/or drugs until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous devices for at least twenty four (24) hours after my release from Dr. Sanders' office or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office for my care. I agree not to drive myself home after sedation, and will have a responsible adult drive me home after my discharge from sedation.

10. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction, due to individual patient differences there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition could occur without the recommended treatment.

11. I have had the opportunity to discuss with the doctor my past medical and health history including any serious problems and/or injuries.

12. I agree to cooperate completely with the recommendations of the doctor while I am under his care, realizing that lack of same could result in a less than optimum result.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE ABOVE CONSENT

_____	_____	_____
WITNESS	**PATIENT, PARENT, OR GUARDIAN**	**DATE**

_____	_____
WITNESS	**DOCTOR**