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INSTRUCTIONS TO PATIENTS HAVING DENTAL PROCEDURES UNDER CONSCIOUS INTRAVENOUS SEDATION

PLEASE READ THIS INFORMATION CAREFULLY PRIOR TO YOUR TREATMENT DATE AND FAMILIARIZE YOURSELF WITH THE FOLLOWING REQUIREMENTS:

Keep this form as a reference until completion of your treatment. You will be asked to sign a consent form prior to your sedation and treatment.

The policies for reserving my appointment time for IV Sedation require a deposit prior to booking my appointment. Once I have paid and booked my appointment, I understand that failure to keep this appointment will result in loss of this deposit.

1. Do not bring your car on the day of surgery unless someone else will drive you home. You are not allowed to operate a motor vehicle for 18 hours following the sedation. Likewise, you should not ingest alcohol, take non-prescription medications, or make critical decisions for 18 hours. You must also arrange to have a responsible adult companion to accompany you home after the sedation and to care for you at home for a minimum of two hours. Sedation cannot be given unless these conditions are met.

2. Do not eat or drink ANYTHING 6 hours before your surgery. Clear fluids (water, apple juice but not milk or orange juice), can be taken up to 4 hours prior to the scheduled time of the treatment. It can be dangerous to have sedation if you disregard these instructions and will necessitate a delay or rescheduling of your operation.

3. Please wear loose, comfortable clothing.

4. In the event of a change in your health, even minor illness, in the week prior to your treatment, please contact us as postponement may be necessary.

5. Medications that are regularly used, especially for heart problems or high blood pressure, need to be taken with a sip of water the day of the surgery.

CONSENT FOR CONSCIOUS SEDATION

I certify that I have read, understand and agree to the conditions as outlined above.
I consent to sedation techniques and/or any other anesthetic procedures as necessary, during the surgical procedure explained to me by Dr. D'Aoust for myself or for my child for whom I certify that I am the legal guardian.

Patient Name: ______________ ______________ ____ ______________
Last First MI Preferred Name

Signature of Patient or Guardian

Signature: ______________________________ Date: __________

Response Date: __________