GRAND AVENUE
DENTAL CARE

Dr. Ryan Ross D.D.S
2911 Grand Ave.
Billings, MT 59102
(406) 245-4922 – (801) 628-3615

ORAL SEDATION CONSENT FORM

*******IF YOU GLAUCOMA, MYASTHENIA GRAVIS YOU CAN NOT TAKE THIS MEDICATION*******
****IF YOU ARE ALLERGIC TO BENZODIAZEPINES YOU CAN NOT TAKE THIS MEDICATION****
*****NO EATING OR DRINKING 6 HOURS PRIOR TO APPOINTMENT*****

I have been instructed to take a pill approximately _____ minutes before my appointment with a minimal amount of water. The anxiolysis appointment will last approximately _____ to _____ hours.

1. I understand that anxiolysis (defined as the diminution of anxiety) will be achieved by the oral administration of _____Halcion (Triazolam), _____Nitrous Oxide/Oxygen, _____Lorazepam (Ativan), _____Diazepam (Valium)

2. I understand that the purpose of anxiolysis is to more comfortably receive dental care. Anxiolysis is not required to provide the necessary dental care. I understand that anxiolysis has limitations and risks and success cannot be guaranteed.

3. I understand that anxiolysis is a drug-induced state of consciousness to reduce fear and anxiety. I will be able to respond during the procedure. My ability to act and function normally returns when the effects of the sedative wear off.

4. I understand and have been informed that the alternatives to anxiolysis are:
   a. No sedation, (b). Nitrous oxide/oxygen inhalation sedation only, (c) Intravenous (I.V.) Sedation, (d) General Anesthesia

5. I understand that there are risks and limitations to all procedures. For anxiolysis these may include:
   a. Inadequate initial dosage. This may result in a sub-optimal level of anxiolysis.
   b. Atypical reaction to the sedative medications. In unusual circumstances this may require emergency medical attention and/or hospitalization. Other atypical reactions may include: altered mental states (e.g. over sedation or hyper responding to the sedative medication), allergic reactions, and nausea and/or vomiting.
   c. If taking an anti-depressant or anti-anxiety medication may compromise the effect of this drug.
   d. If taking non-prescription or OTC drugs or (I.E-street drugs) you may have severe complications and should not take this medication.

6. I understand that if, during the anxiolysis procedure, a change in treatment plan is required, I authorize the dentist to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision. Name of designated proxy _____.

7. I have had the opportunity to discuss anxiolysis and have my questions answered by qualified personnel including the dentist. I also understand that I must follow all the recommended treatments and instructions of my dentist.

8. I understand that I must notify the dentist if I am pregnant, or if I am lactating. I must notify the dentist if I have sensitivity, intolerance, or allergy to any medication. I have informed the dentist of my past and present medical history, if I have recently consumed alcohol or other recreational drugs, and if I am presently on any prescription or non-prescription medications.

9. I understand that after taking oral sedatives I am not permitted to drive or operate hazardous machinery for 24 hours after my procedure. I understand and acknowledge that I will have a responsible adult drive me to and from my dental appointment on the day of the anxiolysis procedure.

10. I understand that by not complying with all of the written and verbal instructions provided to me, I can compromise the safety of the sedation procedure and my health. In most cases, the dentist will not be able to proceed with my treatment.

10. By signing below I hereby consent to anxiolysis in conjunction with my dental treatment.

Patient / Guardian (Signature)_____ Date)_____

Witness_____

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Today's Date: _____

I, _____, give my permission to Dr. Ryan Ross, D.D.S and the associates that they employ, including hired team members to discuss my health and dental situation/treatments with the following persons:

Name_____

Address_____

Contact Numbers: (work)_____(home)_____(cell)_____

This authorization shall be in effect from this day forward, and until I advise Dr. Ryan Ross, D.D.S otherwise in writing.

On this day, _____, I, (print)_____, represent that I am over the age of 18 years, am in sound state and mind, and am competent to enter into this agreement. I am fully aware of and understand the contents of this agreement. All my questions have been answered.

Patient's Signature: _____ Date: _____