

RITA V. PATEL, D.D.S., INC.
CONSENT FOR THE SEDATION OR NITROUS OXIDE FOR
PEDIATRIC DENTAL TREATMENT

I, (parent / guardian's name),
as the legally responsible parent / guardian

of (patient's name),

give my consent to the use of local anesthetics, sedative drugs, or nitrous oxide agents, that Dr(s) of RITA V. PATEL, D.D.S., INC. may deem necessary on the child's s examination chart, as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned treatment.

I have been informed and understand occasionally there are complications of the treatment, drugs, or anesthetic agents, including but not limited to: numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, stroke, or heart attack. I further understand and accept that complications may require hospitalization and may even result in death.

Dr(s) of RITA V. PATEL, D.D.S., INC. discussed with me, to my satisfaction, these complications. I acknowledge the receipt of and understand the preoperative and postoperative instructions. The treatment and sedation or anesthesia procedures have been explained to me, to my satisfaction, along with possible alternative methods and their advantages and disadvantages: risks, consequences, and probable effectiveness of each, as well as the prognosis if no treatment is provided.

I have read this consent and understand, to my satisfaction, the procedures to be performed and accept the possible risks.

Legally responsible parent or guardian: Date:

Witness:

I certify that I have explained the above procedures to the parent or guardian before requesting his or her signature.

Dentist's Signature: Date: