

McKee Dental

NITROUS OXIDE INFORMED CONSENT

I hereby give permission for Dr. Malz, Dr. Woodman and the staff of McKee Dental to administer nitrous oxide sedation during my dental treatment today.

The benefits you can expect from nitrous oxide sedation include:

1. Help in relieving anxiety and pain.
2. Partial reduction or complete elimination of an extreme gag reflex.
3. Assistance with treatment of a medically or cognitively compromised individual.

Patients generally become very relaxed and are always able to communicate with the dentist or assistant. You will also have some control over your own level of sedation if you follow the instructions which you will be given during the procedure.

I understand that the administration of nitrous oxide carries certain risks and side effects which are infrequent, but may occur. They include but are not limited to the following:

1. Sweating and flushing may occur temporarily during administration.
2. Some patients will talk loudly, persistently or experience vivid dreams or giggling. This is always temporary.
3. Shivering at the end of the appointment after nitrous oxide has been terminated is uncommon but, if occurs, only lasts for only a few moments.
4. The most common side effect is nausea/vomiting, although its frequency is still very low. If you feel any discomfort, be sure to tell the doctor/staff so that they can adjust the dosage to eliminate this side effect.
5. You may not feel capable of driving just after termination of nitrous oxide, although after approximately 5 minutes this feeling will be diminished.

I have been advised of alternative treatment, including dental treatment without any form of sedation, possible heavier sedation (oral sedation or IV sedation), or possibly referral to a specialist (pediatric dentist, for example.)

I hereby certify that I understand this authorization and the reasons for the sedative procedure and the uncommon but associated risks. I acknowledge that every effort will be made to create a positive outcome today.

Signature _____

Date _____

Patient Name _____