

# Dental Sedation Consent – Nitrous Oxide & Oral Sedation

Please review and complete this informed consent form regarding the use of nitrous oxide and/or oral sedation for your dental procedure.

## Patient Information

Please provide your personal details below.

**Full Name \***

**Date of Birth (MM/DD/YYYY) \***

**Phone Number \***

**Email Address \***

**Today's Date (MM/DD/YYYY) \***

**Sedation Type Requested (check all that apply) \***

- Nitrous Oxide (Laughing Gas)
- Oral Sedation (medication)
- Nitrous Oxide + Oral Sedation
- Not sure, discuss with provider

**Do you have a history of complications with anesthesia or sedation? \***

- Yes
- No
- Unsure

**If yes, please describe the complications: \***

 Give Feedback

**Are you currently taking any medications? \***

- Yes
- No

**If yes, please list all current medications: \***

**Please check any of the following that apply to you:**

- Asthma
- COPD or other breathing issues
- Sleep apnea
- Heart disease
- High blood pressure
- Liver disease
- Kidney disease
- Pregnancy
- History of substance-use disorder
- Anxiety or panic disorder
- Other

**If any of the above apply, please provide details: \***

**Please list any drug or other allergies:**

**Sedation Expectations & Patient Responsibilities (please read and check each box to confirm): \***

- I understand the effects and purpose of sedation for dental procedures.
- I understand I must have a responsible adult escort for oral sedation.
- I will not drive or operate machinery after sedation.
- I understand the effects of nitrous oxide are short-acting and I may resume normal activities after.
- I will inform the dental team of any changes to my health or medications.

**Risks of Sedation (please read and check each box to acknowledge): \***

- I understand that all sedation methods carry risks including but not limited to nausea, vomiting, drowsiness, allergic reaction, and in rare cases, serious complications.
- I understand that despite precautions, adverse reactions may occur.

**Monitoring & Instructions (please read and check each box to confirm): \***

- I will follow all pre- and post-sedation instructions provided by the dental team.
- I understand I will be monitored during and after the procedure as needed.

**Emergency Authorization (please read and check each box to confirm): \***

- In the event of an emergency, I authorize the dental team to provide necessary medical care and contact emergency services.

**Financial Responsibility (please read and check each box to confirm): \***

- I accept responsibility for all costs associated with sedation and dental treatment, regardless of insurance coverage.

**Consent Confirmation (please read and check each box to confirm): \***

- I have read and understand the information provided above and have had the opportunity to ask questions.
- I consent to the use of sedation as described above for my dental treatment.

**Signature Section**

Please sign and date below to confirm your consent.

**Printed Name (Patient) \***

**Signature (Patient) \***

**Date Signed (MM/DD/YYYY) \***

**Printed Name (Witness/Staff, if applicable)**

**Signature (Witness/Staff, if applicable)**

**Date Signed (Witness/Staff, if applicable)**