

**Jeffery R. Singleton, DMD
Charles L. Clark, Jr., DMD**

**INSTRUCTIONS AND CONSENT FORM
FOR PATIENTS RECEIVING
INTRAVENOUS CONSCIOUS SEDATION TECHNIQUES**

1. **Do not EAT or DRINK anything 6 hours prior to appointment.**
2. Any personal illness, weakness, or known susceptibility must be reported; also, details of drugs recently prescribed or being taken especially sleeping drugs, tranquilizers, or cortisone preparations.
3. Please wear a short sleeve shirt or blouse.
4. A responsible friend or relative **MUST** accompany the patient to the appointment, home from the appointment and aid the patient at their home.
5. Any patient accepting any appointment for these techniques must specifically agree:
 - Not to drive a vehicle or operate any machinery the same day.
 - Not to undertake any responsible business matters.
 - To avoid alcohol.
6. If for any reason the appointment cannot be kept, please give sufficient advance notice for the time to be otherwise allotted.
7. All intravenous solutions are irritating to some degree and although all precautions will be taken to minimize these effects, vein irritation following these procedures can occur. Your doctor will explain this further.

**I HAVE READ THE ABOVE INSTRUCTIONS AND CONSENT TO HAVING
DENTAL TREATMENT DONE WITH INTRAVENOUS CONSCIOUS
SEDATION.**

Signed: _____ Date: _____

Oral Surgery Consent Form

Patient Name: _____ Date: _____

I hereby authorize Jeffery R. Singleton, DMD / Charles L. Clark, Jr., DMD and any associates to perform the following procedures: _____

The doctor and or staff have explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment.

The doctor has explained to me that there are certain potential risks in the treatment plan or procedure. These include:

- _____ 1. Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue to the operated side. This may persist for several weeks, months, or in rare instances, permanently.
- _____ 2. Postoperative infection requiring additional treatment.
- _____ 3. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
- _____ 4. Trismus – Restricted mouth opening for several days or weeks, with possible dislocation of the tempromandibular (jaw) joint.
- _____ 5. Injury to adjacent teeth and fillings.
- _____ 6. In rare circumstances, cardiac arrest or breakage of the jaw.
- _____ 7. Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation.
- _____ 8. Decision to leave a small piece of root in the jaw when its removal requires extensive surgery.
- _____ 9. Stretching of the corners of the mouth with resultant cracking and bruising.

_____ Unforeseen conditions may arise during the procedure that requires a different procedure than as set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary.

_____ I understand that the medications, drugs, anesthetic, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effect. I have also been advised not to smoke for two weeks after the surgery.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

Patient signature _____ Date _____
Witness signature _____ Date _____
Doctor signature _____ Date _____