ENDODONTIC EXCELLENCE

WHERE CARING IS OUR SPECIALTY

International Tower at Reston Heights
11800 Sunrise Valley Drive, Suite #250
Reston, Virginia 20191

703-429-9926
info@endoreston.com
www.endoreston.com

INFORMED CONSENT FOR MINIMAL ORAL SEDATION

Oral sedation is commonly used to manage anxiety, discomfort, and to help patients relax during dental procedures. Local anesthesia will also be used for most procedures. The associated cost is for the personnel and equipment requirements, including an emergency oxygen delivery system, monitoring, and documentation.

I hereby give consent to the treating endodontist and staff to perform Minimal Oral Sedation procedures as follows: 0.25mg triazolam administered orally 1 hour prior to the visit.

Treatment Alternatives

Alternative methods of treatment have been explained to me, such as: Nitrous oxide, Sleep sedation, and No sedation.

Risks and Complications

I understand that there are potential risks and complications associated with the administration of medications, including oral sedation and local anesthesia. These risks include, but are not limited to, the following:

- Adverse drug reactions or side effects which may require emergency medical intervention and/or hospitalization
- Altered mental state, including confusion or memory impairment
- Allergic reactions, ranging from mild to severe
- Nausea and/or vomiting
- Swelling, jaw muscle tenderness, or numbness of the tongue, lips, teeth, jaws, and/or facial tissues, which are typically temporary but may, in rare cases, be permanent

---

Driving and Transportation

I understand that I will not be able to drive after taking the oral sedation medication, as it may impair my ability to operate a vehicle safely. I agree to arrange for a ride to and from my appointment. If needed, transportation arrangements can be made for me.

Ability to Consent During Treatment

I understand that if a change in the treatment plan occurs during the procedure, I may not be able to provide informed consent due to the sedative effects of the medication. In such cases, the office may need to contact a legal guardian or authorized representative to provide consent on my behalf. It is my responsibility to ensure that a guardian or responsible contact is available if necessary.

Acknowledgment and Consent

I understand the proposed procedure, its risks, benefits, and alternatives. I acknowledge that no guarantees have been made regarding the outcome. I voluntarily consent to the treatment and any necessary related procedures.

Patient Name: ______________________________ Date: ______________

Signature of Patient or Legal Guardian: ______________________________

Name of Legal Guardian or Authorized Representative: ______________________________

Phone Number: ______________________