



Nitrous Oxide Informed Consent

PATIENT INFORMATION

First Name		Last Name		Birth Date	
-------------------	--	------------------	--	-------------------	--

I hereby authorize Dr. Benjamin Barborka, Dr. William Brizzzee, Dr. Benjamin Brown and staff to perform nitrous oxide/ oxygen conscious sedation for myself (or my child):

1. I accept and understand that Nitrous Oxide is commonly called laughing gas and provides relaxation. I understand that I (or my child) will be awake and aware of my surroundings, and able to respond rationally to questions and directions.
2. I accept and understand that Nitrous Oxide is an elective procedure.
3. Nitrous Oxide sedation is used for anxiety and pain control, as well as control of gagging. Local anesthesia will also be required.
4. I have been advised of the possible complications associated with Nitrous Oxide. They include, but are not limited to:
 - a) Nausea and vomiting: This is the most frequent of the side effects of Nitrous Oxide sedation but its frequency is still quite low.
 - b) Temporary tingling in the fingers, toes, cheeks, lips, tongue and head or neck area.
 - c) Temporary warm feeling throughout the body with accompanying flushing/blushing.
 - d) Temporary detachment or "out of body" sensation.
 - e) Temporary sluggishness in motion and/or speech.
5. Nitrous Oxide sedation is very effective for many people; however, some people may not like the feeling it produces.
6. For some people, Nitrous Oxide sedation may not calm them adequately to allow a dental procedure to be done. These people may require a different technique for tolerance of a procedure.

FORM COMPLETION

I hereby certify that I understand this authorization and the reasons for the procedure and its associated risks. I have read and understand the above and give my consent to use Nitrous Oxide sedation. I have given a complete and truthful medical history, including all medicine, drug use, pregnancy, ect. I certify that I speak, read and write English. All my questions have been answered before signing this form.

Signature of Patient, Parent or Guardian:		Date:	
--	--	--------------	--

IF PATIENT IS A MINOR

Form signed by:		Relationship to Patient:	
------------------------	--	---------------------------------	--