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ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION AND INFORMED CONSENT
ORAL ANXIOLYSIS ("ORAL SEDATION") CONSENT FORM

1. I have provided an accurate and updated medical history and a list of current medications to my doctor. I understand that the purpose of anxiolysis is to more comfortably receive necessary dental care. Anxiolysis is not required to provide the necessary dental care. I understand that anxiolysis has limitations and risks and absolute Success cannot be guaranteed.

2. I understand that anxiolysis is a drug-induced state of reduced awareness and decreased ability to respond. The purpose of anxiolysis is to reduce fear and anxiety. I will be able to respond during the procedure. My ability to respond normally returns when the effects of the sedative wear off.

3. I understand that anxiolysis will be achieved by the following route: Oral Administration: I will take a pill (or pills) approximately 45 minutes before my appointment time. The onset of many oral anxiolytics is usually 15 to 30 minutes and the peak effect generally occurs between 1 and 2 hours. Effects of the drug are generally almost completely diminished after 6 to 8 hours. In extreme cases, some patients sustain substantial or severe respiratory depression or the need for hospitalization and in very rare cases, possible cardiac arrest or death. Therefore, it is essential to notify the dentist immediately of any untoward reactions or delayed recovery following the procedure.

4. I understand that the alternatives to anxiolysis in this office are: a. No sedation: The necessary procedure is performed under local anesthetic with the patient fully aware; b. Intravenous (IV) Administration: Injection of the sedative in a tube connected to a vein in my arm.

5. I understand that there are risks or limitations to all procedures. For anxiolysis these include:

a. Inadequate initial dosage may require the patient to undergo the procedure without anxiolysis or delay the procedure for another time.

b. Atypical reaction to drugs, which may require emergency medical attention and/or hospitalization such as, altered mental states, allergic reactions, and physical reactions including possible respiratory depression.

c. Inability to discuss treatment options with the doctor should circumstance require a change in treatment plan.

d. Nerve injury, which may occur from the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;

e. Allergic or adverse reactions to medications or materials;

f. Pain, swelling, redness, irritation, numbness and/or bruising in the area where the IV needle is placed. Usually the numbness or pain goes away, but in some cases, it may be permanent;

g. Nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness. Some patients may have an awareness of some or all events of the surgical procedure after it is over;

h. Heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest), or death;

6. If, during the procedure, a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

7. I have had the opportunity to discuss anxiolysis and have my questions answered by qualified personnel including the doctor, if I so desire. I also understand that I must follow all the recommended treatments and instructions of my doctor.

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8. I understand that I must notify the doctor if I am pregnant, or if I am lactating. I must notify the doctor if I have sensitivity to any medication, of my present mental and physical condition, if I have recently consumed alcohol, and if I am presently on psychiatric mood altering drugs or other medications.

9. I will inform the doctor if I am hypersensitive to benzodiazepines (Valium, Ativan, Versed, Halcion etc.)

10. I will not be able to drive or operate machinery while taking oral sedatives for 24 hours after my procedure. I understand I will need to have arrangements for someone to drive me to, if I take the pill beforehand, and from my dental appointment while taking medication.

11. No narcotics shall be taken until 8 hours after completion of the procedure, unless otherwise instructed by the doctor.

12. I authorize photographs of my treatment procedures, which may be taken for the advancement of dentistry and the education of other patients and dentists. My identity will not be revealed without my permission.

Oral Anxiolysis Pre-Operative Instructions:
1. Take regular medications unless specified by Physician or Dentist.
2. Do not eat or drink for at least 4 hours prior to the dental appointment.
3. Eat a light meal and avoid eating fried foods.
3. Patient must be driven to the office by a responsible companion.
4. No smoking or drinking alcohol for 12 hours prior to the dental appointment.
5. Sedative medications must be taken according to Dentist's instructions.
6. Patient must have NO chance of pregnancy.

Oral Anxiolysis Post-Operative Instructions:
1. Take all regular or prescribed medications as outlined by Physician or Dentist.
2. No alcohol for 12 hours post-surgery.
3. No driving for 12 hours post-surgery.
4. Do not operate machinery for 12 hours post-surgery.
5. Must have a responsible companion escort patient home and observe recovery for at least 4 hours.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of oral anxiolysis and have received answers to my satisfaction. I acknowledge that oral anxiolysis is an option and not absolutely necessary for dental treatment, but nevertheless, I accept this option. I do voluntarily assume any and all possible risks including, but not necessarily limited to those listed above, including risk or substantial harm or even death, which may be associated with oral anxiolysis ("oral sedation") drugs. I acknowledge that no guarantees or promises have been made to me concerning the efficacy of oral anxiolysis in my case. The fees for oral anxiolysis have been explained to me and are satisfactory.

By signing this document, I am freely giving my consent to allow and authorize **DR. SAMUEL LEE** and/or his associates or agents to render oral anxiolysis as deemed appropriate and/or advisable to my dental condition, including prescribing and administering appropriate anesthetics and/or medications.

Patient's name:

Choice of Oral Anxiolytic Drug and Planned Dosage:

Signature of patient: