Ridgepoint Dental

CONSENT FOR SEDATION

I, _____, give consent for _____ to

receive dental treatment under sedation and do authorize Dr. _____ to provide the following services:

_____

_____

_____

I understand that the treatment plan may need to be altered during treatment. I authorize

Dr._____ to provide any necessary alternative or additional treatment.

The nature of the dental treatment, the risks and alternatives have been fully explained to me including the risk and alternatives of refusing dental treatment.

All patients undergoing sedation are subject to the risk of medical complications including, but not limited to: sore throat, discomfort, bleeding, swelling, nausea and vomiting, allergic reactions, respiratory and cardiovascular problems and death.

I understand that the explanation of the risks and consequences that I have received is not exhaustive and that other less common risks may arise. I have been advised that these less common risks will be explained to me upon request.

I understand that the sedative medication may not make my child "fall asleep" and that my child may be awake during treatment.

Through my signature, I acknowledge that I have read this document in its entirety and that I fully understand it. I have been given the opportunity to discuss this information and have had all of my questions answered. I request and consent to the above treatment for my child.

_____ _____

Patient/Parent/Guardian's Signature Date

_____

Printed Name