

Benson & Bateh DDS

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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 to allow accessibility for IV and BP cuff.
4. A responsible person with a valid driver's license MUST transport the patient to and from the appointment. This person must stay in the reception area during the entire procedure.
5. Any patient accepting any appointment for these procedures must specifically agree:

Not to drive a vehicle or operate any machinery the same day.
Not to undertake any responsible business matters.
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 MY
DENTAL TREATMENT DONE WITH INTRAVENOUS SEDATION.**

Signed: _____

Date: _____

Benson & Bateh DDS

INFORMED CONSENT FOR SURGERY

I, _____, hereby authorize:
(Name of Patient or Legal Guardian)

_____ and the assistant(s) which he/she
(Name of Dentist(s))

may select to perform or to assist in or observe the following procedure(s):

(State names of all Procedures, Operations and Treatment(s))

on _____
(Self or Name of Patient)

The following items have been discussed and explained to my satisfaction:

- a) The nature and purpose of the above operation(s);
- b) Alternative methods of diagnosis and/or treatment;
- c) Reasonable significant risks.
(i.e., pain, bleeding, infection, sinus involvement
inferior alveolar nerve damage.)

I understand that unforeseen circumstances may arise during the course of the operation(s) which may require other or additional operative or medical procedures. I authorize the dentist(s) named above and his/her assistants to modify the proposed procedure or to perform any added procedures as are necessary or desirable in the exercise of professional judgment.

I agree to the use of anesthesia as required (Nitrous Oxide, IV Conscious Sedation). I understand any tissue removed will be disposed of in accordance with customary practice.

I understand no warranties or guarantees have been made on the outcome of this procedure, treatment or operation(s).

I certify that I have read and fully understand this consent and the matters which have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for and on behalf of the above named patient and that I am signing freely and voluntarily. An offer has been made to answer any questions.

(Patient's, Relative's or Legal Guardian's Signature)

(Date)

(Time)

(Dentist's Signature)

(Date)

Benson & Bateh DDS

REQUEST FOR SURGICAL INSERTION AND RESTORATION OF ENDOSSEOUS IMPLANTS

I, _____ request that Dr. _____ and/or any other dentist or assistant that may be designated surgically expose my jaw bone for the purpose of placing endosseous (in the bone) implants. The entirety of the procedure has been fully explained to me, including the benefits and possible risks. Alternative forms of treatment have also been explained. I have been given the opportunity to ask questions regarding the procedure and they have been answered to my satisfaction. I have not asked for, nor have I received from anyone, a guarantee of the outcome of this procedure.

The purpose of endosseous implants is to provide stability, support and retention for a fixed bridge or crown in the absence of proper natural tooth support. The alternatives of conventional fixed bridge(s) and/or crown(s) have been thoroughly discussed with me.

I further understand and accept the following risks of the surgical procedure:

1. Possible temporary or permanent nerve damage that may cause altered sensation or numbness to the lip, chin, and tongue.
2. Possible exposure and penetration of the maxillary sinus and/or floor of the nose.
3. Possible postoperative infection of the surgical site.
4. Possible complications due to excessive bleeding.
5. Possible temporary swelling and bruising which may be visible on the skin.

I understand the final design of my bridge(s) and/or crown(s) cannot be determined until the implants have fully healed, and that this healing period take from 3-6 months. Failure of an implant(s) to properly heal or problems with implant alignment may result in the alteration of the design or materials used in my bridge(s) and/or crown(s).

I understand the restoration of my dental implant(s) involves precision parts and many steps. Like all materials, the implants and components used to restore them are subject to normal wear and tear. This may include, but is not limited solely to, the loosening or breakage of the implant(s), any of the individual components used to connect the teeth to the implant, and the plastic or porcelain materials used to replace the teeth and gums. I also understand that I will be responsible for the costs of any treatment related to the wear and tear of these components.

Follow-up care for the implants and bridge(s) and/or crown(s) is extremely important for the success of the procedure, and it will be necessary for me to return to the office at regular intervals for examination and service, as required. I will report any significant change in my overall health should it occur following placement of the implants. It has been made clear to me that failure on my part to keep my mouth, implants posts, and prosthesis thoroughly clean may jeopardize the success of the implants. I also realize that immediate postoperative complications and/or other unforeseen long-term factors may necessitate additional surgery, modification of the implants or even surgical removal of the implants. (Over) →

I approve any modification in design, materials or treatment if, in the doctor's professional judgment, he or she feels that it is in my best interest.

One or more of the following will be used for the surgical procedure:

1. Local anesthetic injections.
2. Nitrous oxide/oxygen sedation.
3. Intravenous sedation.
4. Medications given by mouth.

The possible risks and complications of these medications have been explained to me. The type of medications used will be determined in conjunction with me before surgery, but may require alteration at the time of the procedure. I agree not to operate any vehicle or machinery, or engage in any activity which requires reasonable skills, reflexes, or judgment until I am fully recovered from the effects of the anesthesia or drugs given for my care. I understand that a responsible adult who is able to drive must accompany me at the time of my surgery.

Additional Comments:

(Signature of Patient)

(Date)

(Signature of Witness)

(Date)

(Signature of Dentist
Providing Explanation)

(Date)