PDG
Pediatric Dentistry
& Orthodontics

Consent for Minimal or Moderate Sedation

Patient's Full Name: _____ Date of Birth: _____

I hereby authorize Dr. _____ to perform the necessary dental treatment on me/my child utilizing minimal or moderate sedation techniques.

I understand that the procedure will require minimal or moderate sedation, and I consent to the administration of this by the above-named practitioner administering the minimal or moderate sedation.

I have been informed of the fee ($ _____) per appointment for the provision of minimal or moderate sedation in the office based on the type of sedation and duration of dental treatment.

I also understand that during the course of treatment, unforeseen circumstances may arise that make it advisable for an additional or alternate procedure to be performed, which I also consent to being performed.

I acknowledge receiving a copy of the pre-operative and post-operative instructions which have been explained to me. After discharge, I will notify the above-named practitioner if experiences of acute pain, heavy bleeding from the surgical site, respiratory problems, or any other post-operative problems are encountered.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Witness Date

Certified Specialists in Pediatric Dentistry
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