INFORMED CONSENT FOR LOCAL ANESTHETIC

Patient Name: ___________________________ Date: ___________________

Treatment: __________________________________________________________

Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to received dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection.

*Risks include but are not limited to:* It is normal for the numbness to take time to wear off after treatment, usually two to three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured.

Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur.

*Potential benefits:* The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during the dental treatment.

*For All Female Patients:* Because anesthetics, medications and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion, every female must inform the provider of anesthesia if she could be or is pregnant. Anesthetics, medications and drugs may affect the behavior of a nursing baby. In either of these situations, the anesthesia and treatment may be postponed.

_____ I have been given the opportunity to ask questions about the recommended method of anesthesia and believe that I have sufficient information to give my consent as noted below.

_____ I hereby give my consent for the use of local anesthetic, as explained above when Dr. James N. Angelos determines it is indicated in the treatment of _________________________________(Patient’s Name).

OR

_____ I refuse to give my consent for the proposed treatment (s) as described above and understand the potential consequences associated with this refusal.

_____________________________________________ ______________________
Patient or Patient’s Representative Signature Date

I attest that I have discussed the risks, benefits, consequences, and alternatives of anesthesia with the above name mentioned and/or their representative and they have had the opportunity to ask questions, and I believe they understand what has been explained and consents or refuses of treatment as noted above.

_____________________________________________ ______________________
Dentist’s Signature Date

_____________________________________________ ______________________
Witness Signature Date