Patient Name_____

PERIO, PLLC
Dr. John M. Remien DDS, MS
3817 Stephens Ave.
Missoula, MT 59801

CONSENT TO ADMINISTRATION OF SEDATIVES

Our practice is committed to providing our patients with the finest care possible. This includes informing you of the positive and negative possibilities of treatment as well as alternatives. We are guided by our obligation to you and the ethical standards of our profession which require written informed consent signed by the patient.

Type of anesthesia to be administered: Intravenous conscious sedation and/or oral sedative prescription

The nature of, effects, risks of, and alternatives to the administration of the above-described anesthetic agent(s) have been fully explained to me and I understand the explanation. I have had the opportunity to ask questions. All of my questions have been satisfactorily answered and I fully understand the answers.

Although life threatening or other serious complications from the use of the above-described anesthetic agent(s) are extremely rare, there are inherent risks to any sedation. Anesthetic sedatives and anesthetics may cause drowsiness, lack of coordination and lack of awareness. These side effects may be aggravated by the use of alcohol and other drugs.

I agree to NOT consume any alcohol or take any drug except as I am told may be appropriate by my doctor. I understand and agree NOT to operate any vehicle or other hazardous equipment, or to return to work, until I am fully recovered from the effects of any anesthetic or sedative which has been administered.

I will receive post-operative procedure instructions prior to checking out of the office.

Patient's Signature (or Parent/Guardian) _____ Date _____