

**Kevin L. Evans, D.D.S., P.C.**  
**Comprehensive Family Dentistry**

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**NITROUS OXIDE CONSCIOUS SEDATION INFORMED CONSENT**

I, the undersigned, give permission for Dr. Evans and his staff to perform nitrous oxide conscious sedation.

I understand that the administration of medication and the performance of conscious sedation with nitrous oxide carries certain common risks, hazards, and unpleasant side effects which are infrequent but nonetheless may occur. They include but are not limited to the following:

1. Nausea and vomiting – rare but can occur in some individuals. Be sure to tell the doctor or staff if you are experiencing some discomfort. We can quickly adjust the level of sedation to your comfort.
2. Excessive perspiration – a flushed feeling.
3. Behavioral problems – some patients experience vivid dreams or thoughts.
4. Shivering – usually at the end of the procedure.
5. Inability to drive a motor vehicle at end of appointment – You may not feel comfortable or capable of driving after nitrous oxide sedation. If this occurs we will keep you until you feel better or have a friend or cab drive you to insure your safety.

Alternatives include no sedation, i.v. sedation, and general anesthesia. These alternatives also entail risks.

The benefits one can expect from nitrous oxide conscious sedation include relief of anxiety and some pain control, relief of gagging, and reduction of overall stress.

The present fee for nitrous oxide conscious sedation is \$ \_\_\_\_\_.

The risks involved in administration of conscious sedation have been fully explained to me and I do give my free and voluntary informed consent to same. I have had the opportunity to ask questions and I have had my questions answered to my satisfaction. I am aware that the practice of Dentistry is not an exact science. I acknowledge that every effort will be made in my behalf for a positive outcome from sedation, but that no guarantees have been made to me as to the result of this procedure.

\_\_\_\_\_  
Signature of Patient or person authorized to consent for patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date