Consent for Dental Treatment with Minimal or Moderate Sedation PROCEDURE(S):

OPERATING DENTIST: _____

I, the undersigned, hereby consent to the procedure(s) and anaesthesia noted above. I acknowledge that the procedure(s), its implications and possible complications have been explained to me, along with the alternatives including not having any treatment. I understand that the procedures will require minimal or moderate sedation, and I consent to the administration of this by the above-named practitioner. I also understand that during the course of any treatment, unforeseen circumstances may arise that make it advisable for an additional or alternate procedure to be performed and I also consent to such reasonable additional or alternate procedures being performed on me.

Signature _____ Date _____

Patient Parent or Legally Authorized Representative I acknowledge receiving a copy(ies) of the pre- and post-operative instructions which have been explained to me. I understand all the advice given to me by my dentist. After my discharge, I will notify my dentist if I experience any acute pain, heavy bleeding from the surgical site, respiratory problems, or any other post-operative problems.

Signature _____ Date _____

Patient Parent or Legally Authorized Representative