

**PATIENT'S CONSENT FOR DENTAL TREATMENT  
ASSISTED BY MINIMAL OR MODERATE SEDATION**

PROCEDURE: Sedation for Dental Procedure

OPERATING DENTIST: Dr. Sylvia Kowalewski

PRACTITIONER ADMINISTERING SEDATION: Dr. Sylvia Kowalewski

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Patient\_\_ Parent\_\_ Legally Authorized Representative

**Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

I acknowledge receiving a copy 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\_\_ Legally Authorized Representative

**Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

