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 postoperative problems.

Signature ________________________________ **Date**____________________
Patient / Parent / Legally Authorized Representative

Witness ________________________________ **Date**____________________