



NITROUS OXIDE INFORMED CONSENT FORM

At Durst and Jones Family Dental we take all necessary steps to make your visit a very pleasant dental experience. We offer nitrous oxide sedation to patients who feel like they may need it. Please read the terms stated below if you have in the past or think that you presently may be interested in the use of nitrous oxide sedation.

The purpose of this Informed Consent Form is to provide an opportunity for patients (and/or their parents or guardian) to understand and give permission for the use of Nitrous Oxide when provided along with dental treatment.

- ___ **1** I accept and understand that Nitrous Oxide is commonly called laughing gas and provides relaxation, although I will be awake, fully conscious, aware of my surroundings, and able to respond rationally to inquiries and directions.
- ___ **2** I accept and understand that the use of Nitrous Oxide is not required to provide the necessary dental care.
- ___ **3** I accept and understand that the purpose of Nitrous Oxide is to make it more comfortable for me to receive the necessary dental care with less pain and/or anxiety. I also accept and understand that the use of Nitrous Oxide has limitations and risks and absolute success cannot be guaranteed.
- ___ **4** I realize that the fee for Nitrous Oxide sedation is **\$65** for the first hour administered and then **\$35** for each additional hour.

The use of Nitrous Oxide has been **fully explained to me**, including all risks involved. I have been fully informed that **temporary complications** may include, but are not exclusive of: tingling in the fingers, toes, cheeks, lips, tongue, head or cheek area; heaviness in the thighs and/or legs, followed by a lighter floating feeling; resonance in the voice or presence of a hyper nasal tone; warm feeling throughout body, with flushed cheeks; fits of uncontrollable laughter or giddiness; detachment or disassociation from environment may occur; intense an uncomfortable warm and/or hot feeling throughout body; lightweight or floating sensation with an accompanying "out of body" sensation; sluggishness in motion and slurring and/or repetition of words; feeling of nausea; vomiting; agitation; and/or hallucination. **All of these complications are temporary.**

- ___ **5** I accept and understand that I must follow all recommended instructions.
- ___ **6** I have informed the doctor of my complete medical history including any recent surgeries or changes in my medical history involving lung, respiratory, ear infection or common cold. I also accept and understand that I must notify the doctor of my present mental and physical condition.
- ___ **7** I accept and understand that I must notify the doctor if I: (1) am pregnant, (2) have sensitivity to any medication, (3) have recently consumed alcohol, and or (4) am presently on psychiatric mood altering drugs or other medications.

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