FLORIDA DENTAL ANESTHESIA SERVICES, LLC. • TEL: 786.486.3392 • INFO@FLORIDADENTALANESTHESIA.COM

Consent for Anesthesia

Patient Name _____ Date of Birth _____

Date of Appointment _____

The following information is provided to inform you of the choices, risks and benefits involved with having treatment under general anesthesia (this includes sedation - concious, deep and general anesthesia - asleep, unconcious).

I (Patient or Legal Guardian) _____, hereby authorize Florida Dental Anesthesia Services or its agents to perform the anesthesia procedure as previously explained to me and any other procedure deemed necessary or advisable as an adjunct to the planned anesthetic procedure. I consent to the administration of such anesthetic(s) by any route suitable by the anesthesiologist, who is an independant contractor and consultant. I understand that the anesthesiologist will have full charge of the administration and maintenance of the anesthesia and that this is an independent function from the operation.

I understand that there are potential complications associated with the administration of anesthetic drugs including, but not limited to, pain, hematoma, phlebitis, numbness, swelling, bleeding, bruising, nausea, vomiting, aspiration and allergic reaction. I further understand that complications may require hospitalization and could result in death.

I have been fully advised of the planned anesthetic and accept the potential risks and dangers. I acknowledge that I have had the opportunity to ask questions about my anesthetic and I am satisfied with the information provided to me.

Signature of Patient (or Legal Guardian)_____

Date

Print Name_____

Office Use Only:

Witness_____**Date**_____

Patient Name:_____

Name of dentist performing procedure:_____