south shore pediatric dentistry

NITROUS OXIDE/OXYGEN SEDATION INFORMED CONSENT FORM

Nitrous oxide (commonly called “laughing gas”) is an analgesic and mild sedative used by numerous pediatric dentists. Nitrous oxide/oxygen sedation decreases fear, anxiety, apprehension and pain sensations by improving the ability for receptive communication. The feeling of nausea or vomiting can be a temporary rare side effect. It is a safe gas/oxygen mixture, which is inhaled by a nasal mask and takes effect in 5 minutes and is eliminated from the body immediately following the end of its administration.

— I accept and understand that the purpose of nitrous oxide is to make it more comfortable for my child to receive the necessary dental care with less pain and/or anxiety. I also accept and understand that the use of nitrous oxide/oxygen sedation has limitations and absolute success cannot be guaranteed.

— I accept and understand that if the patient will not accept the mask, nitrous oxide/oxygen cannot be used.

— I accept and understand that the alternatives to nitrous oxide/oxygen sedation at South Shore Pediatric Dentistry, LLC are:

a) No nitrous oxide: the necessary dental procedure is performed under local anesthesia only.

b) General Anesthesia: this will be performed at a hospital with an anesthesiologist

— I have had the opportunity to discuss nitrous oxide/oxygen sedation in conjunction with my child’s dental care provider and have had the opportunity to ask questions and am fully satisfied with the answers I have received.

— I have and will inform the doctor if my child or anyone accompanying my child into the treatment room is pregnant. I understand that they will be asked to remain out of the room during the administration of nitrous oxide.

— I have and will inform the doctor of my child’s complete medical history including any recent surgeries, mood altering medications, or change in my child’s medical history involving respiratory, ear infection, or common cold. I also accept and understand that I must notify the doctor of my child’s present mental and physical condition.

Patient Name: _____

Parent/ Legal Guardian Name: _____

Parent/ Legal Guardian Signature: _____ **Date:** _____

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