Southern Office-Based Anesthesia
PO Box 2656 Henderson, NC
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# INFORMED CONSENT FOR ANESTHESIA

Patient Name: _____

Patient safety is of our utmost concern. Serious complications are rare and not to be expected. The anesthesiologist will be present with the patient for the entirety of the procedure. Advanced anesthesia equipment required by the state of North Carolina will be present and patient's vital signs will be monitored throughout the procedure. However, there are certain risks that are inherent to the administration of anesthesia. These include but are not limited to: bruising or tenderness at the IV or IM (shot) site, soreness of the mouth, lips, nose or throat, temporary dizziness, blurred vision, weakness and impaired judgment, postoperative drowsiness, nausea and/or vomiting. For these reasons, the patient is advised to avoid driving or making major decisions for 24 hours following anesthesia. Children undergoing anesthesia should have direct parental supervision 24 hours following anesthesia. Extremely rare complications of general anesthesia such as anaphylaxis, malignant hyperthermia, cardiac dysrhythmias or arrest, and vomiting with aspiration would require emergency transport and hospitalization.

As in the case with normal operating room procedures, family members will NOT be allowed to be present during the procedure.

I, _____ , have had the risks and potential complications as well as the anesthetic plan explained to me. I understand that I am responsible for the costs of treating any potential complications that require additional medical treatment. I have had all of my questions answered to my satisfaction and agree to proceed with the anesthetic. I hereby authorize an anesthesiologist from Southern Office-Based Anesthesia to provide anesthesia services and any other procedure deemed necessary or advisable as a corollary to the planned anesthetic procedure. I understand the anesthesiologist assumes no liability from the dental treatment performed, and that the dentist assumes no liability from the anesthesia performed.

FEMALES: I understand that anesthesia may be harmful to the unborn child and may cause birth defects or spontaneous abortions. I accept full responsibility for informing the anesthesiologist of the possibility of being pregnant, a confirmed pregnancy, and/or being a nursing mother.

**The patient will have nothing to eat or drink (nothing by mouth) after 12 AM the night before the appointment (unless otherwise specified). Even small amounts of food given before anesthesia may result in serious life-threatening complications requiring emergency services and hospitalization.**

These restrictions are for the safety of the patient. I acknowledge the pre-operative fasting regulations and will ensure that they are followed.

| _____ | _____ | _____ |
|---|---|---|
| Patient/Responsible Party (PRINT) | Signature | Date |

## HIPAA Privacy Statement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to: 1) Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2) Obtain payment from third-party payers.

| _____ | _____ | _____ |
|---|---|---|
| Patient/Responsible Party (PRINT) | Signature | Date |