DENTAL SERVICE GROUP

AUTHORIZATION FOR AND CONSENT TO DENTAL TREATMENT UNDER GENERAL ANESTHESIA / IV SEDATION

Your physicians and dental surgeons have determined that the operation or special procedures listed below may be beneficial in a diagnosis or treatment of your condition. Upon your authorization and consent, such operations or special procedures will be performed for you by your physicians and dental surgeons and/or by other physicians and dental surgeons selected by them.

These surgical operations, special diagnostic or therapeutic procedures and the administration of anesthesia/sedation may involve calculated risks of complications, injuries, or even death from both known and unknown causes, and no warranty or guarantee has been made as to result or cure. These operations or procedures are, therefore, not performed upon patients unless and until the patient or parent/legal guardian has had an opportunity to discuss them with this physician and dental surgeon. It is understood that a treatment plan may have to be changed during surgery due to changing conditions or conditions which were unanticipated/ undetected during examination. Each patient has the right to consent to or to refuse any proposed operation or special procedure (based upon the description or explanation received).

Your signature opposite the operations or special procedures listed below constitutes your acknowledgement that you have read and agreed to the following:

1. That the operations or special procedures have been adequately explained to you by your attending physicians or dental surgeons and that you have all the information that you desire.
2. That you authorize and consent to the performance of the operations or special procedures named and whatever procedures may be deemed necessary or advisable in addition to the planned operation.
3. That you consent to the administration of anesthetics and drugs as may be considered necessary or advisable by those physicians under whose care you hereby place yourself.
4. That you consent to blood testing and to Dental Service Group accessing the results of these tests (such as Hepatitis B, Hepatitis C, and HIV) in Alberta Netcare and other electronic health records for the purpose of treating yourself and/or any Dental Service Group employee who may be exposed to your blood or bodily fluids.
5. That you have fully disclosed all medical information and drug usage, prescription and/or recreational, to your dental surgeon. You understand that failure to disclose any and all drug usage could result in serious medical complications including drug contraindications.
6. That if you are female you are not pregnant.

Operation and Procedure: .....

By: ..... Date of service: .....

....

Name of Patient (please print) Signature of Patient Signature of Witness(es)

If the patient is a minor or unable to sign, complete the following:

Patient is a minor ..... years of age/____ months of age. The patient is unable to sign because: .....

.....

As parent or legal guardian, I hereby sign on his/her behalf.

....

Signature Name (please print) Relationship

.....

Signature of Witness / Date