Consent for Nitrous Oxide Analgesia
(Supplemental use of "Laughing Gas")

Patient Name: _____ Date: ___/___/_____

. **<u>Use of Nitrous Oxide requires that we obtain your consent</u>**.

[ ] For Teeth Cleanings, you will be given Nitrous Oxide Analgesia.

[ ] For Dental Treatment, you will be given Nitrous Oxide Analgesia along with Local Anesthetic ("Novocaine") which will produce the "numb" feeling.

You will be awake and aware of the dental procedure being performed.

The use of Local Anesthetic will reduce or completely eliminate any pain or discomfort.

NITROUS OXIDE is also known as "laughing gas". You will be relaxed and somewhat less aware of your surroundings, as well as less responsive to minor discomfort, and you may or may not recall much of the procedure.

The Equipment calibrates the percentage of Nitrous Oxide with 100% Pure Oxygen. NITROUS OXIDE and OXYGEN are breathed through the nasal mask and after a state of relaxation is reached, local anesthesia may be administered.

NITROUS OXIDE has few lasting effects but you will need a short time period for recovery, after the dental procedure, when you will be breathing in 100% Oxygen.

It is important that you read and understand the information below and that you prepare by following the instructions carefully. If you are unclear about anything, please ask your doctor.

1. Recovery time from Nitrous Oxide is usually very short, but may be prolonged in some people, requiring them to remain in the office for a period of time following the dental procedure.
2. It is best to arrange for a responsible friend or family member to be "on call" if you need assistance leaving the office.
3. For long, involved or extensive dental procedures, it is best to have someone accompany you.
4. Plan to rest for several hours following the dental procedure.

I understand that the use of Nitrous Oxide, although usually safe and without lasting consequences, may affect me differently. I am prepared to deal with any undesirable side effects of Nitrous Oxide and understand that those possibilities may occur. I agree to the use of Nitrous Oxide Analgesia to supplement the Local Anesthesia planned for my procedure.

Patient or Guardian Signature: _____ Date: ___/___/____

Guardian's Relationship to the Patient: _____

Doctor Signature: _____ Date: ___/___/____

Witness Signature: _____ Date: ___/___/____