DARCY A. WAKEFIELD, DDS, LLC
Family & Cosmetic Dentistry
951 Steubenville Ave.
Cambridge, Ohio 43725
740-435-3100

Informed Consent For N20/02 Sedation

I understand that my treatment today will include the procedure of N20/02 administration.

I, _____, have been informed of the purpose of the procedure and how it will benefit my treatment. The procedure has been described to me and I understand how it will be accomplished. I should feel more relaxed and less anxious.

I understand that certain risk(s) may be associated with this procedure, such as headache, dizziness, nausea and vomiting. Some patients at high levels of N20 can experience dreaming and hallucinations. I understand the risk(s) associated with this procedure and I further understand the risk(s) that may occur if the procedure is not completed.

I also realize that Dr. Wakefield must know if I have taken any type of medication or drugs within the last seventy-two (72) hours because these may cause an adverse reaction when N20/02 is administered, I verify that I have told Dr. Wakefield about my medications or drugs.

I have been informed of the alternatives to N20/02 sedation and their associated risks.

All of my questions and concerns have been satisfactorily answered and addressed.

Therefore, I give my informed consent to the administration of N20/02 sedation and agree to hold harmless, release, and indemnify agent, servants, students, and employees of office/clinic of Darcy A. Wakefield, DDS, LLC from any and all causes of action, claims, demands, or liability that may arise out of such treatment on behalf of myself, my heirs, my executors, administrators or assigns; or on behalf of my minor child or children or his /her (their) heirs, executors or administrators or assigns.

Signed: _____ Date: _____
(Patient, Parent, or Guardian)

Witness: _____ Date: _____