Davidson Family Dental

2624 Commercial Way Ste. C

Rock Springs, WY 82901

307-362-4005

Seeing Patients During Covid-19 Consent Form

Patient Name _____ Date of birth _____

You are consenting to care during the events of the COVID-19 National Emergency.
Please be advised that there are risks in being in the proximity of health care personnel including, dentists and associated team members.

While we strictly follow all OSHA and CDC guidelines at our office, we are taking additional precautions to prevent the spread of this new novel virus. I understand the COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and may still be contagious. Dental procedures may need water spray, vacuums and ultra-fine nature of the spray can linger in the air, which can transmit COVID-19 virus. As usual, we follow strict sterilization protocols of all instruments used in your mouth. If it cannot be sterilized, we are utilizing single use barriers and disposables that are for one-time use. While this drastically lowers the possibility of transmission it does NOT completely eliminate it.

Having read the above:

I Understand the risks involved in seeking treatment during this period. I will follow the office policy on pre-operative rinsing and hand washing. (Initial each statement if true and sign below.)

_____I have not traveled, had a fever or cold, cough, sore throat, shortness of breath for over 2 weeks and I have practiced social distancing.

_____I consent to be seen today to take care of my dental needs and understand the risks involved.

_____ I have been given the opportunity to asks questions and consent to treatment.

Print Name: _____

Signature: _____

Date: _____

Thank you for your cooperation during this time of national emergency.

Sincerely,

Dr. _____

NITROUS OXIDE INFORMED CONSENT

I hereby authorize **Davidson Family Dental**
to perform nitrous oxide/oxygen conscious sedation for myself (or my child/ward):

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1. I accept and understand that Nitrous Oxide is commonly called laughing gas and provides relaxation. I understand that I (or my child) will be awake, fully conscious, aware of my surroundings, and able to respond rationally to questions and directions.

2. I accept and understand that Nitrous Oxide is an elective procedure and not required to provide the necessary dental treatment. I am aware that the alternative to completing the necessary treatment with Nitrous Oxide is to use local anesthetic ONLY.

3. Please advise the doctor and staff of your complete medical history, including any surgeries. Advise them of any changes in your medical history including if you or your child has a cold, upper respiratory infection, asthma, or difficulty breathing, this may affect how well the nitrous oxide will work.

4. Nitrous oxide sedation is used for anxiety and pain control, as well as control of gagging. Local anesthesia will also be required for most procedures.

5. I have been advised of the possible complications associated with Nitrous Oxide. They include, but are not limited to:
   a) Nausea and vomiting: This is the most frequent of the side effects of nitrous oxide sedation but its frequency is still quite low.
   b) Temporary tingling in the fingers, toes, cheeks, lips, tongue and head or neck area
   c) Temporary warm feeling throughout the body with accompanying flushing/ blushing.
   d) Temporary detachment or "out of body" sensation.
   e) Temporary sluggishness in motion and/or speech.
   f) Shivering – usually at the end of the procedure.

6. Nitrous oxide sedation is very effective for many people, however; some people may not like the feeling it produces, or it may produce increased activity in some people, at which time you or the dentist may decide to discontinue nitrous oxide sedation.

7. For some people nitrous oxide sedation may not calm them adequately to allow a dental procedure to be done. These people may require referral for other sedation techniques.

I hereby certify that I understand this authorization and the reasons for the above named sedative procedure and its associated risks. I am aware that the practice of dentistry is not an exact science. I acknowledge that every effort will be made in my (or my child's) behalf for a positive outcome from sedation, but no guarantees have been made as to the result of the procedure authorized above.

_____ _____

Date Patient or Patient's Guardian Signature

_____ _____

Date Witness Signature