NITROUS OXIDE INFORMED CONSENT

I hereby authorize Southern Illinois Pediatric Dentistry to administer nitrous oxide for my child:

_____

(child's name)

1. I accept and understand that nitrous oxide (commonly referred to as "laughing gas") provides relaxation and reduction in anxiety.
2. I accept and understand that nitrous oxide is an elective procedure and is not required for the necessary dental treatment. However, other alternatives that may be required to safely and adequately complete the necessary dental procedure(s) include restraint (papoose board) or general anesthesia.
3. Please advise the doctor and staff of your child's complete medical history, including any surgeries. Advise them of any changes in your child's medical history including if your child is currently ill.
4. Nitrous oxide is useful not only for anxiety control, but can also be effective in controlling some mild to moderate gag-reflexes.
5. Nitrous oxide can have some (temporary) side effects including, but not limited to:
    a. Nausea and vomiting- although very rare, it may occur. It is not necessary to avoid eating leading up to the procedure, but would not be advisable for eating a large meal immediately before the procedure. Remember that your child will likely be numb for 1-2 hours following the procedure and will be unable to chew any food during that time.
    b. Tingling of fingers and toes
    c. Feeling of warmth throughout the body
    d. Feeling of euphoria/uncontrollable laughing
6. Nitrous oxide is very effective for many children. However, it does not guarantee successful completion of all dental treatment if the child remains too active throughout the procedure.

I hereby certify that I understand this authorization and the reasons for the use of nitrous. I acknowledge that every effort will be made to ensure a positive outcome for my child's dental treatment. I further acknowledge that I have had the opportunity to discuss the use of nitrous oxide and that all questions have been answered to my satisfaction.

Date Parent/Guardian Signature

Date Witness

Tooth Extraction: Informed Consent

Patient's Name: _____ Date of Birth: _____

Why does the tooth need to be extracted?

There are multiple reasons a tooth may need to be removed. If a tooth becomes infected secondary to decay or trauma, it must be removed. Leaving the tooth untreated may result in pain, abscess, swelling and spread of infection. In other instances, an orthodontic specialist may recommend tooth removal to accommodate a more beneficial orthodontic outcome.

What are the risks and complications?

- **Pain or Discomfort**: This may occur at the site of tooth removal once the numbing sensation wears off. The patient may also experience stretching, cracking, or bruising at the corners of the mouth.
- **Damage to Adjacent Teeth**
- **Incomplete Root Removal**: Pieces of the root may be left behind if removing them poses a risk to the developing permanent tooth bud. If this occurs, the roots will often resorb on their own.
- **Bleeding**: Some bleeding may occur if the blood clot is disturbed. Applying pressure with gauze should stop the bleeding.
- **Space Loss**: When a baby tooth is lost prematurely, the adult tooth may not be ready to come into its position. This may result in space loss that may require orthodontic treatment to regain.

I understand tooth extraction is deemed necessary by the dentist, in the best interest of the patient's oral health. I understand that by refusing this treatment, the patient is at risk for pain, abscess, swelling and spread of infection.

I have read and understood the above. My questions have been answered. I understand this is an irreversible procedure and I give my consent for removal of the following tooth/teeth:

_____

Parent/guardian: _____ Date: _____