CONSCIOUS SEDATION CONSENT

I acknowledge that Vincent T. McClane, D.M.D. has explained to me in general terms oral anxiolysis, the alternatives (including non-use) and the risks and inconveniences. I am aware of the conditions that may preclude the use of oral anxiolysis and confirm that I do not fall into any of these conditions or categories. I have been given the opportunity to ask any questions and any such questions have been answered or explained to my satisfaction. I authorize Vincent T. McClane, D.M.D. to use his professional judgement to manage any conditions that might unexpectedly arise during the course of the procedure. By signing below, I acknowledge that I have been given time to read and have read the information in the attached document. I understand this form and I consent to the administration of oral anxiolysis.

PATIENT NAME: _____

SIGNATURE: _____DATE: _____

PATIENT'S AUTHORIZED REPRESENTATIVE
(If patient is under 18 years of age or you are consenting to the care of another)

I have the legal authority to sign this consent on behalf of:

MINOR PATIENT'S NAME: _____

YOUR RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____DATE: _____

PATIENT'S DESIGNATED DRIVER
(MUST BE OVER 18 YEARS OF AGE)

NAME OF DRIVER: _____

PRIMARY PHONE#: _____