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CONSENT FOR LOCAL ANESTHESIA AND N2O ANALGESIA

This is my consent and I voluntarily request for local anesthetic and/ or inhalation analgesia depending upon the judgment of the doctors involved with my care.

I have been informed and understand that occasionally there are some complaints with anesthesia and/or medications. These Include but are not limited to:

- Nausea and vomiting
- Allergic reaction
- Cardiovascular collapse
- Swelling
- Bruising

Anesthetics, medications and prescriptions may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised to refrain from operating any vehicle or hazardous devices until fully recovered from the effect of the anesthetic or medication that may have been given to me for my care.

I acknowledge the receipt of and understand postoperative instructions and will arrange for a postoperative visit if necessary. It has been explained to me and I understand there is no warranty or guarantee as to any result and/or cure. I understand I may ask for a full recital of all possible risks attendant to phase of my care by just asking.

Patient/Guardian Signature _____ Date _____

Print Name _____