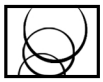


OLD ORCHARD PERIODONTICS
AND IMPLANT DENTISTRY

Pre-Anesthesia Instructions

Office Anesthesiology and Dental Consultants is delighted to provide you or your family member with the best level of office-based anesthesia care. As you receive this document, you should have completed the pre-anesthesia medical evaluation with your Dentist Anesthesiologist. Please read this list of instructions carefully. Not adhering to those instructions can significantly increase the risk under General Anesthesia or Sedation.

1) You must not eat or drink anything after midnight on the night prior to your procedure or a minimum of 8 hours before the procedure. This includes water, gum, breath mints.
2) If you are prescribed medications that have to be taken as instructed by your primary care physician, please do not use more than one ounce of water. Likewise, if oral sedative pills are used before the scheduled appointment, they too can be taken with a limited amount of water. This should also be done in coordination with your anesthesiologist. Please do not use orange juice, milk or the like for such purposes.
3) If you are diabetic, you will have to adjust your insulin or diabetes medications based on your anesthesiologist's instructions.
4) You should arrive about 30 minutes prior to the schedule appointment to complete the necessary paper work and undergo a rapid reassessment of health status.
5) There should be no smoking for at least 24 hours prior to anesthesia. If you are using nicotine patches, you should have them removed at least 24 hours prior to anesthesia.
6) To facilitate the placement of monitors, please wear loose fitting clothing.
7) Please arrange to have a family member or a trusted adult friend to escort you since driving or performing any activities that require full alertness after anesthesia is not allowed for the rest of the day. We strongly recommend traveling by car.
8) If you are an adult who will take a sedative pill prior to coming to your appointment, you need to discuss and sign your informed consent with your Dentist Anesthesiologist prior to the schedule anesthesia date.
9) Patients under age 18 must have a parent or a legal guardian consenting to the anesthesia procedure.
10) Please leave all valuable and jewelry at home.
11) Contact lenses should not be worn that day. You can wear glasses the day of the procedure.
12) If you wear dentures or other types of Dental appliances, please remove them before surgery.
13) Please remove any nail polish or plastic artificial nails to assure accurate monitoring.
14) Please make sure you use the restroom prior to starting.
15) If you develop cold or flu-like symptoms or any other illness, please contact your Dentist Anesthesiologist as soon as possible. Cancellations, otherwise should not be done any later than 48 hours prior to the appointment in extreme circumstances by contacting _____.

I understand that I have to obtain all medical evaluations requested by my Dentist prior to having the procedure done. I take full responsibility to disclose full and accurate medical history. Recreational drugs, if being used, can cause serious and possibly irreversible damage with adverse anesthesia outcome including possible death. I will inform my anesthesiologist of any use of alcohol, marijuana, cocaine, heroin or any other elicit drugs.

_____ _____

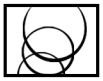
Patient Date

_____ _____

Parent/Guardian Date

_____ _____

Witness Date



OLD ORCHARD PERIODONTICS
AND IMPLANT DENTISTRY

Post-Anesthesia Instructions

1) **Buckle-up in the car on the way home. Child safety seats should be placed within the visibility of the parents to monitor the child during the ride.**
2) **Plan on a day of rest after receiving anesthesia.**
3) **Do not plan on conducting any strenuous activities or any that require full alertness for the rest of the day. This includes but is not limited to driving, operating dangerous machinery or leaving home alone.**
4) **Children should not be allowed to ride their bikes, play in the street or do other activities that can put them at the risk for injury after anesthesia.**
5) **Resume your regular medications as instructed by your physician and by the anesthesiologist. Insulin and diabetes medications should be taken with food or a carbohydrate-containing drink.**
6) **If you were given pain medications with codeine or a similar narcotic by your Dentist/Surgeon, maintain a log of the time you took each dose since residual amnesia from the anesthetic can cause you to forget some of your activities on the day of the procedure. This can put you at the risk of unintentionally overmedicating.**
7) **Maintaining adequate hydration is very important. Advance your diet as tolerated throughout the day while observing the post-surgical instructions given to you by the Dentist/Surgeon.**
8) **If there is nausea and vomiting which persists until the evening contact your physician for possible need of anti-nausea medications or intravenous fluids.**
9) **If you have any questions or concerns, please contact Office Anesthesiology and Dental Consultants at the above listed numbers or e-mail. In the case of an emergency make sure you call 911 and have immediate medical assistance.**
10) **Follow your post-surgical follow-up instructions as directed by your Dentist/Surgeon.**

Patient's Signature: **Date:**

Parent/Guardian Signature: **Date:**

Witness Signature: **Date:**

The anesthetic procedure which will be performed was described to me as well as the alternatives and risks. All my questions were unanswered to my satisfaction. I fully understand that in the course of anesthesia care, the planned technique might be changed due to unexpected circumstances that can take place during or after the procedure.

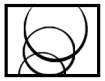
I certify and acknowledge that I have read this form or had it read to me, and have had a satisfactory opportunity to ask questions and give my informed consent (permission). I understand the expected results of the procedure, its risks and alternatives for carrying it out. I hereby accept such risks as described above.

Patient's Signature: **Date:**

Signature of Parent or Guardian: **Date:**

Relationship to the patient:

Witness: **Date:**



OLD ORCHARD PERIODONTICS
AND IMPLANT DENTISTRY

Consent for Performance of Conscious Sedation

1) I authorize the administration of anesthesia upon myself or _____

2) I consent to receiving the following type of anesthetic:

-----a) Conscious Sedation: With this type of anesthetic there will be a state of relaxation and reduced anxiety. There will be a reduced state of pain sensation. The depth of sedation will vary from one procedure to the other. **This technique usually does not produce total unconsciousness.** The anesthetic medications are administered through injection into the veins, breathing gases, intramuscular injection as well as other techniques or a combination of the described techniques could also be used.
Risks of this technique include but are not limited to: Exaggerated response to the sedative anesthetic producing unconsciousness. Shallow or depressed breathing can result, as well as injury to the blood vessels.

-----b) Intra and extra-oral local anesthetic blocks: With this technique the various oral and peri-oral structures are anesthetized through the injection of local anesthetics that will numb-up a certain region of the mouth or surrounding structure to carry out the desired Dental or surgical procedure. The expected results include complete or partial loss of sensation in the area where the procedure is being performed.

Risks of this technique include but are not limited to: Swelling and edema in the area of injection, infection, nerve damage resulting in temporary or permanent numbness in the lip or an area of the mouth or surrounding structure, temporary or permanent pain sensation in the mouth or surrounding structure, Rigidity in the facial muscles.

3) I fully recognize that the effect of anesthesia can cause a less alert state and lead to lesser coordination and attention for a period of time after the cessation of the anesthetic. I acknowledge and accept that I (or my child/minor patient) will not perform any functions that require full alertness and otherwise would put the patient at risk of harm for, at least, the remainder of the day on which the anesthetic was performed. Minor problems could result from the anesthetic which can include: Nausea and vomiting, pain in the site of injection or in the blood vessels with possible swelling and bruising, sore throat, muscle pain. Injury can result in the eyes, teeth, mouth as well as other injuries related to positioning during the procedure.

4) I understand that the patient's overall health state can influence the level of risk under anesthesia. In healthy patients, serious complications are infrequent. I understand that there is no guarantee that there will be no serious complications. Such rare but serious complications can include but are not limited to: Unexpected reactions to the medications, heart attack or other heart complications, loss of sensation or brain damage, excessive bleeding, injury to or loss of limb function as well as paralysis, even death. **I hereby authorize UIC Periodontal Department team to perform any emergency resuscitative procedure that might be needed in order to save my/minor patient's life in the unlikely event of an unanticipated emergency occurring. This also includes the decision to transport the patient to a hospital via ambulance to provide emergent medical care if necessary.**

The anesthetic procedure which will be performed was described to me as well as the alternatives and risks. All my questions were unanswered to my satisfaction. I fully understand that in the course of anesthesia care, the planned technique might be changed due to unexpected circumstances that can take place during or after the procedure.

I certify and acknowledge that I have read this form or had it read to me, and have had a satisfactory opportunity to ask questions and give my informed consent (permission). I understand the expected results of the procedure, its risks and alternatives for carrying it out. I hereby accept such risks as described above.

Patient's Signature: **Date:**

Signature of Parent or Guardian: **Date:**

Relationship to the patient:

Witness: **Date:**