Dr. Nick Seddon, DMD, FICOI
Cosmetic, Implant, and General Dentistry

MINIMAL AND MODERATE SEDATION SERVICES

PATIENT NAME: _____

PROCEDURE(S)

_____

_____

_____

OPERATING DENTIST: _____Dr. Nick Seddon_____

I, the undersigned, hereby consent to the procedure(s) noted above. I acknowledge that the procedure(s), its implications and possible complications have been explained to me, along with the alternatives including not having any treatment. I understand that the procedure will require minimal or moderate sedation, and I consent to the administration of this by Dr. Nick Seddon of the minimal or moderate sedation. I also understand that during the course of any treatment, unforeseen circumstances may arise that make it advisable for an additional or alternate procedure to be performed, which I also consent to being performed on me.

Signature _____ Date _____

Patient *Parent* *Legally Authorized Representative*

Witness _____ Date _____

I acknowledge receiving a copy of the pre- and post-operative instructions which have been explained to me. I understand all the advice given to me by Dr. Nick Seddon and his assistants. After my discharge, I will notify my dentist if I experience any acute pain, heavy bleeding from the surgical site, respiratory problems, or any other post-operative problems.

Signature _____ Date _____

Patient *Parent* *Legally Authorized Representative*

Witness _____ Date _____

drNickSeddon
changing lives one smile at a time

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