

**LIBERTY ANESTHESIOLOGY ASSOCIATES**  
PHILADELPHIA, PA

**CONSENT FOR PRE-SEDATION AND GENERAL ANESTHESIA**

PATIENT NAME: \_\_\_\_\_ SURGERY DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

The listed patient management, pre-sedation and general anesthesia techniques have been explained to me. Side effects are possible, although they are usually minor and include dry mouth, nausea, thirst, shivering, vomiting, short memory lapse, mild bloody nose or a sore jaw, and in rare circumstances serious illness or death. Local anesthetics may cause numbness, tingling, nausea, or headaches. Alternate techniques, if any, have also been explained to me, as have the advantages and disadvantages of each. I understand that some combination of these techniques may be used for completing the dental treatment.

I understand that patient management techniques, pre-sedation and anesthesia will be used in a safe, efficient manner according to the guidelines set forth by the American Society of Anesthesiologists, and the State Dental Advisory Task Force as indicated in Mental Retardation Bulletin # 99-81-54 issued by the Department of Public Welfare on December 31, 1981.

I understand that Liberty Anesthesiology Associates is an independent corporation providing anesthesia services to Special Smiles, Ltd. I further understand that Special Smiles, Ltd is a licensed tenant at Temple University Hospital – Episcopal Division and that no services are being provided by Temple University Hospital – Episcopal Division.

**ACKNOWLEDGEMENT**

**I HEREBY GIVE PERMISSION FOR LIBERTY ANESTHESIOLOGY ASSOCIATES, AN INDEPENDENT CORPORATION PROVIDING SERVICE WITH SPECIAL SMILES, LTD TO ADMINISTER GENERAL ANESTHESIA. I UNDERSTAND THAT UNANTICIPATED CIRCUMSTANCES MAY CALL FOR CHANGES IN THE PLANNED ANESTHETIC. I THEREFORE AGREE TO ANY CHANGE IN THE MANAGEMENT OF ANESTHESIA AS DEEMED NECESSARY BY THE ANESTHESIOLOGIST.**

**I acknowledge that I have read and understand this consent, and that all questions about patient management, pre-sedation and general anesthesia have been answered in a satisfactory manner. I further understand that this consent form is invalid if altered but that I have the right to be provided with answers to questions, which may arise during the course of treatment.**

**I certify that I am the legal guardian of the above referenced patient or have otherwise been empowered to give consent on behalf of the patient. This consent shall remain in force for 60 days after date signed or unless otherwise terminated by me.**

\_\_\_\_\_  
Name of Parent/Guardian (please print full name)

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name of Witness (please print full name)

\_\_\_\_\_  
Phone Number of Legal Guardian



100 EAST LEHIGH AVENUE, CENTENNIAL TWO, PHILADELPHIA, PA 19125  
215-707-0575 TELEPHONE 215-707-0848 FACSIMILE  
[www.specialsmilesLtd.com](http://www.specialsmilesLtd.com)

**CONSENT FOR COMPREHENSIVE DENTAL TREATMENT**

PATIENT NAME: \_\_\_\_\_ SURGERY DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

It is the philosophy of our dental practice to preserve the entire dentition (set of teeth) of our patients. We recognize the importance of maintaining all teeth in order to support appearance, function, as well as the overall oral habits of our patients. We choose treatment options that are the best choice for each particular oral disease or condition a patient may have. Our treatment selections promote the overall and long-term health of the patient. We encourage you to contact us in order to speak with one of our dentists in *advance* of the patient’s appointment should you have any questions.

I authorize the dentist(s) of Special Smiles, Ltd to provide comprehensive oral rehabilitation for the above referenced patient. I understand that the dental treatment may include, but is not limited to the following treatments: comprehensive examination, full mouth x-ray series, clinical photographs for record keeping and teaching purposes, cleaning, periodontal scaling and root planing, fluoride treatment, minor periodontal surgery, soft tissue excision and biopsy of lesions, amalgam and composite tooth restorations, stainless steel crowns, extractions and limited root canal treatment.

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**ACKNOWLEDGEMENT**

**I hereby acknowledge that I have read and understand this consent, and that all questions about the proposed dental treatment have been answered in a satisfactory manner. I further understand that this consent form is invalid if altered but that I have the right to be provided with answers to questions, which may arise during the course of treatment.**

**I certify that I am the legal guardian of the above referenced patient or have otherwise been empowered to give consent on behalf of the patient. This consent shall remain in force for 60 days after date signed or unless otherwise terminated by me.**

\_\_\_\_\_  
Name of Parent/Guardian (please print full name)

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name of Witness (please print full name)

\_\_\_\_\_  
Phone Number of Legal Guardian



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### INFORMATION REGARDING TOOTH EXTRACTION

PATIENT NAME: \_\_\_\_\_ SURGERY DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

It is the philosophy of our dental practice to preserve the entire dentition (set of teeth) of our patients. We recognize the importance of maintaining all teeth in order to support appearance, function, as well as the overall oral habits of our patients. However, there are situations where tooth extraction is the best or only treatment option for the overall and long-term health of the patient. We choose this option carefully.

Please read the following information, and contact our office *in advance* to discuss any questions you may have with the attending dentist before signing the consent form for comprehensive dental treatment. This list is intended to review the most common risks associated with tooth extraction, however it is not limited to the following:

- Postoperative discomfort and swelling that may require several days of at-home recuperation
- Prolonged or heavy bleeding that may require additional treatment or surgery
- Injury or damage to the adjacent teeth, fillings, tooth restorations or bridge work
- Postoperative infection that may require additional treatment including hospitalization and surgery
- Stretching of the corners of the mouth that may cause cracking and bruising that may heal slowly
- Restricted mouth opening and pain sometimes related to swelling and muscle soreness
- The decision to leave a small piece of root in the jaw, when its removal would require extensive surgery or risk of other complications
- Injury to the nerve under the lower teeth may result in temporary numbness, pain or tingling of the chin, lip, cheek, gums or tongue. This condition may persist for several weeks, months or in rare situations, may be permanent. In very rare cases, when the nerve to the tongue is injured, an alteration in speech or taste may occur
- Opening of the maxillary sinus (a hollow space in the bone located above the upper teeth) that may require additional surgery or a course of antibiotics and nasal decongestants

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#### ACKNOWLEDGEMENT

**I acknowledge that I have read and understand the risks and consequences of tooth extraction as described above, and all questions have been answered to my satisfaction. I further understand that this form is invalid if altered but that I have the right to be provided with answers to questions, which may arise during the course of treatment.**

**I certify that I am the legal guardian of the above referenced patient or have otherwise been empowered to give permission on behalf of the patient. This form shall remain valid for 60 days after date signed or unless otherwise terminated by me.**

\_\_\_\_\_  
Name of Parent/Guardian (please print full name)

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

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Relationship to Patient

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Name of Witness (please print full name)

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Phone Number of Legal Guardian