ASSOCIATES IN ANESTHESIA, INC.

INFORMED CONSENT TO THE ADMINISTRATION OF GENERAL ANESTHESIA

Patient Name: ______________________________ DOB: ____________ Surgery Date: ______/______/______

1. The above-named patient (the "**Patient**") will receive general anesthesia to facilitate dentistry.

2. General anesthesia is a controlled, drug induced state of unconsciousness, accompanied by partial or complete loss of protective reflexes, including an inability to independently maintain an airway and/or respond purposefully to physical stimulation or verbal command.

3. Usually, an intravenous catheter is placed and an endotracheal (breathing) tube is passed through the nostrils during this anesthetic. While dentistry often is performed under local anesthesia, under sedation or without anesthesia altogether, Associates In Anesthesia, Inc. has been asked to provide general anesthesia to the Patient for dental treatment.

ACKNOWLEDGEMENT:

I certify that I am the Patient, the legal guardian of the Patient, or have otherwise been empowered to give consent on the Patient's behalf.

I acknowledge that informed consent for dental treatment has been obtained separately.

I understand that common side effects of anesthesia include: nausea, vomiting, headache, backache, sore throat, hoarseness, and epistaxis (bleeding from the nose). More serious and unexpected risks also can occur. These risks include, but are not limited to: damage to teeth, mouth, vocal cords, corneal abrasions, pneumonia, numbness, and allergic or adverse drug reactions. I understand that rare events such as dreams or recall of inoperative events, heart attack, stroke, paralysis, damage to liver, kidneys or other organs, permanent brain damage, and death can occur. I understand that the risks apply to every method of anesthesia.

I have been made aware of the medically significant risks and consequences associated with the administration of general anesthesia, and I understand that general anesthesia is not an exact science and no guarantee about the outcome can be made.

I have also been made aware that, by calling the front office at Special Smiles, Ltd. at 267-639-6250, I may schedule a phone meeting with a physician staff member of Associates In Anesthesia, Inc. (the "**Anesthesiologist**") to ask any questions that I might have concerning the proposed administration of general anesthesia, associated risks, any alternative methods of administration, associated risks, and the possible results of not receiving pre-sedation and/or general anesthesia.

I acknowledge that I have read and understand this Informed Consent to the Administration of General Anesthesia (this "**Consent Form**"), and that all my questions about patient management, pre-sedation, and general anesthesia have been answered in a satisfactory manner. I agree to not alter this Form and further agree that such alterations will be invalid.

I further acknowledge that I have been given an opportunity to ask questions that I might have concerning the proposed administration of general anesthesia, associated risks, any alternative methods of administration, and associated risks and that I have been provided all information that I have requested.

I HEREBY AUTHORIZE, CONSENT, AND GIVE PERMISSION TO ASSOCIATES IN ANESTHESIA, INC. AS AN INDEPENDENT CONTRACTOR OF SPECIAL SMILES LTD, PEDIATRIC DENTAL ASSOCIATES, LTD, CHILDREN'S DENTAL MANAGEMENT AND KIDS SMILES, INC., TO ADMINISTER GENERAL ANESTHESIA UNDER THE DIRECTION OF A PHYSICIAN STAFF MEMBER OF ASSOCIATES IN ANESTHESIA, INC. (THE "**ANESTHESIOLOGIST**"). 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.

THIS CONSENT SHALL REMAIN IN FORCE FOR 90 DAYS AFTER THE DATE SIGNED BY LEGAL GUARDIAN.

______________________________ Name of Parent/Guardian (please print full name)	______________________________ Signature of Anesthesiologist/Date
______________________________ Signature of Parent/Guardian	______________________________ Signature of Witness/Date
______________________________ Relationship to Patient	______________________________ Name of Witness (Please Print)
______________________________ Phone Number of Legal Guardian	
______________________________ Date	