

## **Informed Consent for Local Anesthesia**

I understand that my dental treatment may require the use of a local anesthetic for pain control. I understand that a local anesthetic may consist of different medications that are injected into the cheek, jaw or gum area. These drugs may include, lidocaine, prilocaine, mepivacaine, bupivacaine, articaine, or others. I understand that local anesthetics may contain a “vasoconstrictor” like epinephrine; antioxidants, such as sulfites or methylparaben for preservation of the solutions; sodium hydroxide, and sodium chloride.

I understand that local anesthetics will cause a section of my mouth to become numb, with the numbness lasting up to several hours. I know that while my mouth is numb I must be careful not to bite my lips or tongue.

Local anesthetics are among the most common drugs used in a dental office. Complications and side effects are rare, but may include, among others not listed on this sheet:

- Swelling, bruising, or soreness at the injection site.
- A blood filled swelling called hematoma, can form when a needle used during an injection hits a blood vessel.
- Temporary numbness outside of the mouth making an eyelid or mouth “droop”.
- Temporary rapid heartbeat.
- Damage to the nerves resulting in temporary or possibly permanent numbness or tingling of lips, chin, tongue or other areas.
- Severe and possible life threatening allergic reactions necessitating emergency care.

I understand that if I have uncontrolled high blood pressure, uncontrolled thyroid problems, angina, or have recently had a heart attack, I will inform my dentist without fail as these conditions have caused complications for persons receiving local anesthesia. I will also inform the dentist of any prescription or over-the-counter medications I am taking as these may interact with local anesthetics. I understand my dentist’s recommendation of local anesthetic for all the dental procedures that requires adequate pain control, risks of the local anesthetics, any alternatives and risks of these alternatives, including consequences of doing nothing. This consent for local anesthetics remains valid every time I seek any treatment in this office. I have had all of my questions answered, and have not been offered any guarantees.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_