Valencia Oral & Maxillofacial Surgery

David L. Baker, D.D.S.

<u>Consent for Treatment</u>

This is my consent for David L. Baker and/or his associate(s) to perform the oral surgery as indicated below and administer anesthesia as discussed and deemed desirable to facilitate the planned operation.
*Removal of Teeth #'s*____

I understand that the purpose of the procedure is to treat and possibly correct or prevent pathologic (diseased or malformed) conditions associated with my teeth and oral/facial tissues. The doctor advised me that if this condition persists without treatment or surgery, my present condition may worsen in time, and the risks to my health might include, but are not limited to the following: swelling pain infection, cyst formation, periodontal disease, malocclusion, pathologic fracture of the jaw, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative treatment. I understand that there are certain inherent and potential risks with any treatment pain, and more specifically, that in oral surgical procedures these risks include but are not limited to.

1). Post-operative discomfort, discoloration and swelling that may necessitate several days of home recuperation.
2). Bleeding from operative site possible bruising or discoloration of the surrounding tissues.
3). Numbness and tingling of the lips, chin gums, check, teeth and/or tongue (especially from removal of lower teeth) which may persist for several weeks, months or in remote instances, may be permanent.
4). Stiffness of the jaws or facial muscles and change in the bite or jaw joints that may last for several days or weeks.
5). Injury to adjacent tissue, teeth, or restorations especially if they are in a weakened condition due to the presence of decay or large restorations.
6). Headache or referred pain to the ear and neck.
7). Unfavorable reaction to medications such as nausea or allergy.
8). Sinus complications resulting from the removal of upper teeth, or, surgery on the (upper) teeth, which may require additional treatment.
9). Possible fracture of the mandible (lower jaw) associated with the removal of the lower molar teeth.
10). Decision to leave a small piece of tooth or root in the jaw when its removal might injure vital structures.
11). Stretching of the corners of the mouth with resultant cracking or bruising.
12). Post-operative infection requiring additional treatment.
13). If intravenous medication is used, soreness, stiffness or bruising at the injection site or along the vein may develop which could require limiting the use of the arm or further treatment until it resolves.

During the course of the procedure, unforeseen conditions may be revealed that necessitate an extension of the original procedure or a different procedure than set forth above. I therefore authorize that such procedures as are necessary and desirable be performed in the exercise of the professional judgment. The combination of surgery, anesthesia, prescriptions and other factors may cause drowsiness and lack of awareness and coordination. This can be increased by the use of alcohol or other drugs. I agree not to operate any motor vehicle or hazardous equipment for at least 24 hours after my release from surgery and until I feel fully recovered from the effects of anesthetic medications, pain medications and the surgery itself. I understand that it is advisable to have a responsible adult drive me home following any oral surgery and that this is a requirement if I have received any intravenous medication. There is a possibility that certain drugs interact, especially contraceptives (birth control pills). To avoid the possibility of an unplanned pregnancy, an additional form of birth control should be used until your next menstrual cycle if you have been given these medications.
I have discussed with the doctor my past medical history including any serious problems, diseases and injuries.
I agree to cooperate completely with the recommendations of the doctor while I'm under his care, realizing that any lack of same could compromise my recovery.
No guarantee or warranty has been given to me that the proposed treatment will be curative and, or successful to my complete satisfaction.
Due to individual patient differences, there exists a risk of failure, relapse or worsening of a condition despite the care provided.
I certify that I have had an opportunity to read and fully understand the above consent to my satisfaction.

Signature of Patient/Responsible Party: ____ *Date:* _____________