CONSENT FOR ORAL SURGERY

Patient name _____

I hereby authorize _____ (doctor name) and any associates to perform the following procedure: _____

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment.

The doctor has explained to me that there are certain potential risks in this treatment plan or procedure. These include:

1 Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side; this can persist for several weeks, months or, in rare instances, permanently

2 Postoperative infection requiring additional treatment

3 Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery

4 Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint

5 Injury to adjacent teeth and fillings

6 In rare circumstances, cardiac arrest or breakage of the jaw

7 Postoperative discomfort, swelling and bleeding that may necessitate several days of recuperation

8 A small piece of root left in the jaw when removal would require extensive surgery

9 Stretching of the corners of the mouth with resultant cracking and bruising

10 _____

_____

_____

Unforeseen conditions may arise during the procedure that require a different procedure than set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgement, they are deemed necessary.

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs at the same time because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile or hazardous devices while taking such medications and until fully recovered from their effects.

It has been explained to me and I understand that a perfect result is not guaranteed or warrantied.

Please don't hesitate to ask the doctor or staff if you have any questions.

_____ _____

Patient (guardian if patient is a minor) Date

_____ _____

Dentist signature Date

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