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wisdom Teeth Only | Heath Hendrickson, D.D.S.

SURGICAL CONSENT

Patient's Name Date

I hereby authorize Dr. Heath Hendrickson and associated staff to perform the following procedure:

REMOVAL OF THIRD MOLARS (WISDOM TEETH) under IV Sedation

or other:_____

Please initial each paragraph after reading. If you have any questions, please ask your doctor.

1. I understand that there are known consequences of surgery and the administration of drugs and anesthetics, which include (but are no limited to): pain and discomfort, swelling, bleeding, bruising and infection. Changes in the bite or restricted mouth opening secondary to stress on the jaw joint (TMJ) may occur. There is also the possibility of injury to adjacent teeth or other tissues of the mouth, bone/jaw fractures, delayed healing, dry socket or unexpected drug reactions or allergies.

_____ initials

2. With tooth extraction, I understand that there may be unexpected damage to adjacent teeth or fillings, sharp ridges or bone splinters that may require later surgery to smooth or remove, dry socket which may require additional care, or small fragments of tooth root which may be left in place to avoid damage to vital structures such as nerves or sinus.

_____ initials

3. Lower tooth roots may be very close to the nerve and surgery may result in pain or a numb feeling of the chin, lip, cheek, gums, teeth or tongue lasting for weeks, months or may rarely be permanent. On upper teeth, where root are close to the sinus, a sinus infection may develop, a root tip may enter the sinus and/or an opening from the mouth to the sinus may occur which could require later medication or surgery.

_____ initials

4. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis), which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the rare risks of heart irregularities, heart attack, stroke, brain damage or death.

_____ initials

SURGICAL CONSENT (p.2)

5. **<u>YOUR OBLIGATION IF IV ANESTHESIA IS USED</u>**

a. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are recovered sufficiently to care for yourself. This may be up to 24 hours.

b. During recovery time (24 hours) you should not drive, operate complicated machinery or devices or make important decisions such as signing documents, etc.

c. You must have a completely empty stomach. **<u>IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!</u>**

d. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or medications provided by this office, using only a small sip of water.

_____ initials

6. I understand that no guarantee can be promised and I give my free voluntary consent for treatment. I realize that my doctor may discover conditions requiring different surgery from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgment.

_____ initials

INFORMATION FOR FEMALE PATIENTS

7. I have informed by doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effects of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment and to continue those methods until advised by my personal physician that I can return to the use of birth control pills.

_____ initials

CONSENT

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read and write English.

_____

Patient's (or Legal Guardian's) Signature Date

_____

Witness Signature Date

_____

Driver's Name Age Phone