



CONSENT FOR ORAL SURGICAL PROCEDURE & ANESTHESIA

As a patient scheduled to have surgery involving my teeth and surrounding bone, I understand that the purpose of the procedure is to treat and possibly correct my diseased oral tissues. I realize that without treatment, my present oral condition will probably worsen in time, and risks to my health may include but are not limited to the following: swelling, pain, infection, cyst formation, periodontal (gum) disease, dental caries, malocclusion, pathological fracture of the jaw, premature loss of teeth, and/or permanent loss of bone. I understand the possible alternative treatment, if any, but have freely chosen the planned procedure. I am aware that in any surgical procedure, there are inherent and potential risks. I understand that in this particular instance, such operative risks include but are not limited to

- INITIAL _____ Post-operative swelling and discomfort, which may necessitate several days of home recuperation.
- INITIAL _____ Heavy bleeding that may be prolonged.
- INITIAL _____ Injury to adjacent teeth, fillings, or restorations.
- INITIAL _____ Post-operative infection requiring additional treatment.
- INITIAL _____ Stretching, cracking, and/or bruising of the corners of the mouth.
- INITIAL _____ Restricted mouth opening for several days or weeks.
- INITIAL _____ Decision to leave a small piece of root in the jaw when its removal requires extensive surgery.
- INITIAL _____ Breakage or fracture of the jaw.
- INITIAL _____ Injury to the nerves in the area, which can result in numbness, tingling, or pain in the lip, chin, gums, teeth, and/or tongue. This may persist for weeks, months, or rarely, permanently.
- INITIAL _____ Involvement of the sinus in the upper jaw, resulting in an opening into the mouth.
- INITIAL _____ Possible TMJ pain/dysfunction (jaw joint).
- INITIAL _____ Possible loss/failure of implant or bone graft.

I understand that the anesthesia methods offered to me were dependent upon my medical history, and I have had the opportunity to discuss my medical history and present physical condition with the doctor. If I select general anesthesia or intravenous sedation, I agree not to eat or drink for eight (8) hours prior to the procedure and to have a responsible adult drive and accompany me following the procedure. I realize that there are certain risks that could involve serious injury inherent to any procedure done using general anesthesia or intravenous sedation.

If I selected local anesthesia for pain control, I realize that nerve injury, bruising, or severe and harmful bodily reactions to the medication, though unlikely, are possible.

I realize that I should not operate any vehicle, automobile, or hazardous device, nor consume alcoholic beverages while under the effects of medication given to me for use during or following this procedure. If any unforeseen conditions arise during the procedure calling for additional treatment from that now contemplated, I request and authorize whatever measures deemed advisable by the doctor. I realize that there is no guarantee that the proposed treatment will be curative and/or successful to my complete satisfaction. I am aware that individual patients' differences result in the risk, relapse, selective re-treatment, or worsening of the present condition despite the care provided. I understand that failing to follow instructions concerning my care will increase the chances of a less-than-optimal result. I certify that I read and write English and have read and fully understand this consent for surgery and anesthesia. I have asked the doctor any questions I have concerning this consent form, and they have been answered to my satisfaction. Consent is hereby given for the following operation(s):

SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR: _____ **DATE:** _____

SIGNATURE OF WITNESS: _____ **DATE:** _____