

INFORMED CONSENT FOR ORAL SURGERY.

You have the right to be informed about your condition and the recommended treatment so that you may make an informed decision as to whether or not to undergo **the** procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to properly inform you so that you may give or withhold your consent.

PATIENT

NAME: _____ **DATE:** _____

If you have any questions, please ask the doctor **BEFORE** signing.

I. I hereby authorize Dr. _____, and any other agents, assistants, or employees selected by him, to perform the following treatment/procedures

_____ as previously explained to me, or other procedures deemed necessary or advisable to complete the planned operation.

2. I understand that I have other forms of treatment, or no treatment at all. I understand that this is my choice alone, and that the risks of those choices have been presented to me.
3. My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance such risks include but are not limited to the following:

- 1) POSTOPERATIVE DISCOMFORT AND SWELLING THAT MAY REQUIRE AT-HOME .
RECUPERATION
- 2) PROLONGED OR HEAVY BLEEDING THAT MAY REQUIRE ADDITIONAL
TREATMENT
- 3) INJURY OR DAMAGE TO ADJACENT TEETH OR FILLINGS .
- 4) POSTOPERATIVE INFECTION THAT MAY REQUIRE ADDITIONAL *TREATMENTS*) STRETCHING OF
THE CORNERS OF THE MOUTH THAT MAY CAUSE CRACKING AND BRUISING
- 6) RESTRICTED MOUTH OPENING DURING HEALING; SOMETIMES RELATED TO SWELLING AND
MUSCLE SORENESS AND SOMETIMES RELATED TO STRESS ON THE JAW JOINTS (TMJ),
ESPECIALLY WHEN TMJ PROBLEMS ALREADY EXIST
- 7) THE DECISION TO LEAVE A SMALL PIECE OP ROOT IN THE JAW WHEN ITS REMOVAL
WOULD REQUIRE EXTENSIVE SURGERY OR RISK OTHER COMPLICATIONS.
- 8) FRACTURE OF THE JAW (IN VERY COMPLICATED EXTRACTIONS)
- 9) INJURY TO THE NERVE UNDERLYING THE LOWER TEETH RESULTING IN NUMBNESS OR
TINGLING OF THE CHIN, LIP, CHEEK, GUMS AND OR TONGUE WHICH MAY PERSIST FOR SEVERAL WEEKS,
MONTHS, OR IN RARE INSTANCES PERMANENTLY.

10) OPERING OF THE SINUS (A NORMAL CAVITY SITUATED ABOVE THE UPPER TEETH)
REQUIRING ADDITIONAL SURGERY OR TREATMENT

11) DRY SOCKET-LOSS OF THE BLOOD CLOT FROM THE EXTRACTION SITE.

12) LOCAL ANESTHESIA: CERTAIN POSSIBLE RISKS EXIST THAT, ALTHOUGH RARE, COULD INCLUDE PAIN, SWELLING, BRUISING, INFECTION, NERVE DAMAGE, AND UNEXPECTED ALLERGIC REACTIONS WHICH COULD RESULT IN HEART ATTACK, STROKE, BRAIN DAMAGE AND/OR DEATH..

13) ADDITIONAL PROCEDURE-SPECIFIC RISKS OR SIDE EFFECTS THAT APPLY ONLY IF YOU ARE HAVING THE PROCEDURE LISTED:

A) APICOECTOMY: THERE IS A POSSIBILITY OF LOSS OF THE TOOTH DESPITE THE SURGERY, DUE TO RECURRENT INFECTION .

B) TOOTH EXPOSURE: THERE IS A POSSIBILITY THAT THE TOOTH CANNOT BE BROUGHT INTO POSITION. THERE IS ALSO THE RISK OF DAMAGE TO ADJACENT TEETH AS A RESULT OF THE POSITION OF THE TOOTH OR THE PROCESS OF BRINGING IT INTO CORRECT POSITION.

No guarantee or assurance has been given 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, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that treatment would be helpful, and that a worsening of my condition would occur sooner-without the recommended treatment.

I certify that I have had an opportunity to read and fully understand the above terms within the above consent and the explanation made, and that all the blanks or statements requiring completion were filled and any inapplicable paragraphs were stricken before I signed. I also state that I speak, read, and write English.

PATIENT'S (LEGAL GUARDIAN'S) SIGNATURE DATE

WITNESS' SIGNATURE _____ **DATE** _____

DOCTOR'S SIGNATURE _____ **DATE** _____