Consent for Oral Surgery Procedures

Patient Name: _____ **Date:** _____

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____1. This is my consent for my surgeon to perform the following treatment/procedure/surgery, and any other procedure deemed necessary by my surgeon and his/her surgical team who is working with him/her:
Removal of tooth #/ teeth #s: _____
Diagnosis: _____

_____2. I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral/maxillofacial tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time, and the risks to my health may include, but are not limited to, the following: swelling, pain, infection, cyst formation, periodontal (gum) disease, dental caries, malocclusion, pathologic fracture of jaw, premature loss of teeth and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

_____3. My surgeon has explained to me that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance such operative risks include, but are not limited to:

a. Postoperative discomfort and swelling that may necessitate several days of at-home recuperation.
b. Bleeding that may be prolonged.
c. Injury or damage to adjacent teeth, fillings and crowns.
d. Postoperative infection that may require additional treatment.
e. Stretching of the corners of the mouth with resultant cracking and bruising.
f. Restricted mouth-opening for several days or weeks.
g. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
h. Fracture of the jaw.
i. Injury to the nerve underlying lower teeth resulting in numbness or tingling of the chin, lip, cheek, gums, tongue and/or loss of taste on the operated side; this may persist for several weeks, months or, in rare instances, permanently.
j. Opening of the sinus cavity (a normal cavity situated above the upper teeth) requiring additional treatment.
k. Temporal mandibular joint (TMJ) disorders, clicking, popping, grinding and limited opening requiring further treatments.
l. Dry socket (loss of blood clot from extraction site).
m. Allergic reactions (previously unknown) to any medications used in treatment.

_____4. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile or hazardous devices, or return to work, while taking such medications and /or drugs; or until fully recovered from the effects of anesthetic medication and drugs that may have been given to me in the office or hospital for my care. If sedative drugs have been given to me at the time of surgery, I agree not drive myself home after surgery and will have a responsible adult drive me and accompany me home after my discharge from surgery.

_____5. I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires a general or intravenous anesthetic. I consent to the administration of **local / nitrous oxide / IV anesthesia**.

_____6. I am aware that local anesthesia has potential risks and complications; swelling, bleeding, bruising and possible nerve injury, usually temporary causing prolonged numbness and discomfort in the injected areas.

_____7. No guarantee or assurance 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, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that the therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

_____8. I have had an opportunity to discuss with my surgeon my past medical and health history including any serious problems and/or injuries.

_____9. I agree to cooperate completely with the recommendation of my surgeon while I am under his/her care, realizing that failure to do so could result in a less than optimal result.

_____10. It has been explained to me by my surgeon and I understand that there can be potential complications with the healing of bone when taking bisphosphonate medications such as (Fosamax, Boniva and Actonel). I have been informed that there are higher risks of non-healing bone when performing surgery if I have ever taken Aredia and Zometa. I also understand that there currently is no cure for the non-healing bone and will assume all risks of having any procedures performed by the doctor.

_____11. I agree that I have been given verbal and written pre and postoperative care instructions.

FEMALE PATIENTS ONLY:

_____ It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medications are completed.

I certify that I have had an opportunity to fully read the above consent and I understand the terms and words within, as well as any explanations made or referred to. I certify that all blanks or statements requiring insertion or completion were filled in and non-applicable paragraphs, if any, were stricken out before I signed. I also state that I speak, read, write and understand English.

My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

Patient *(or Legal Guardian)* Signature **Date**

Witness Signature **Date**

Doctor Signature **Date**

Rev 12/18