American Dental

INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA*

*PATIENT IS TO INITIAL EACH PARAGRAPH AFTER READING.

PATIENT'S NAME _____ DATE OF BIRTH _____

This is my consent for Dr. _____ and/or any oral and maxillofacial surgeon who is working with him/her to perform the following treatment/procedure/surgery: _____

_____

_____

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

I understand that the purpose of the procedure/surgery is to treat and to 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) diseases; 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.

Doctor _____ has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to: (check items applicable)

___ 1. Postoperative discomfort and swelling that may necessitate several days of home recuperation.

___ 2. Heavy bleeding that may be prolonged.

___ 3. Injury to adjacent teeth and fillings.

___ 4. Postoperative infection requiring additional treatment.

___ 5. Stretching of the corners of the mouth with resultant cracking and bruising.

___ 6. Restricted mouth opening for several days or weeks.

___ 7. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.

___ 8. Breakage of jaw.

___ 9. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side: this may persist for several weeks, months, or, in remote instances, permanently.

___ 10. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

___ 11. Other _____

I agree and understand I am not to have and/or have not had anything to eat or drink for _____ hours

_____ before my surgery.

I consent to administration of such local and/or general anesthesia as deemed necessary by

_____ Dr. _____ and/or his/her designated assistants to accomplish the proposed procedure.

I certify that I have not taken any street drugs or nonprescribed medication within the last 24 hours, including but not limited to cocaine, heroin, and marijuana. I realize that by not revealing this information, I place myself

_____ under significant risk for the surgical procedure and the anesthesia.