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**CONSENT FOR ORAL SURGERY**

AS A PATIENT SCHEDULED TO HAVE SURGERY INVOLVING MY TEETH, SURROUNDING BONE, AND/OR SOFT TISSUES, I UNDERSTAND 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, PATHOLOGIC FRACTURE OF THE JAW, PREMATURE LOSS OF TEETH, AND/OR PREMATURE LOSS OF BONE. I UNDERSTAND THE POSSIBLE ALTERNATIVE FORMS OF 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:

1. POSTOPERATIVE SWELLING AND DISCOMFORT WHICH MAY NECESSITATE SEVERAL DAYS OF HOME RECUPERATION.
2. HEAVY BLEEDING THAT MAY BE PROLONGED.
3. INJURY TO ADJACENT TEETH, FILLINGS, OR RESTORATIONS.
4. POSTOPERATIVE INFECTION REQUIRING ADDITIONAL TREATMENT.
5. STRETCHING, CRACKING AND/OR BRUISING OF CORNERS OF MOUTH.
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 OR FRACTURE OF THE JAW OR DISABLING INJURY TO THE JAW JOINTS.
9. INJURY TO THE NERVES IN THE AREA WHICH CAN RESULT IN NUMBNESS, TINGLING OR PAIN OF THE LIP, CHIN, GUMS, CHEEK, TEETH AND /OR TONGUE OF THE OPERATED SIDE. THIS MAY PERSIST FOR WEEKS, MONTHS, OR IN REMOTE INSTANCES PERMANENTLY.
10. INVOLVEMENT OF THE SINUS IN THE UPPER JAW, RESULTING IN AN OPENING INTO THE MOUTH.

I UNDERSTAND THAT THE ANESTHETIC METHODS OFFERED TO ME WERE DEPENDENT UPON MY

PAST MEDICAL HISTORY, AND I HAVE HAD OPPORTUNITY TO DISCUSS MY MEDICAL HISTORY AND PRESENT PHYSICAL CONDITION WITH THE DOCTOR.

IF I SELECTED GENERAL ANESTHESIA, I AGREE NOT TO EAT OR DRINK FOR 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 WHICH COULD INVOLVE SERIOUS BODILY INJURY OR DEATH INHERENT IN ANY PROCEDURE DONE USING GENERAL ANESTHESIA. IF I SELECT LOCAL ANESTHESIA FOR PAIN CONTROL, I REALIZE THAT NERVE INJURY, BRUISING, OR SEVERE AND HARMFUL BODILY REACTIONS TO THE MEDICATIONS, THOUGH UNLIKELY, ARE POSSIBLE.

I REALIZE THAT I SHOULD NOT OPERATE ANY VEHICLE, AUTOMOBILE, DANGEROUS MACHINERY, OR HAZARDOUS DEVICES; NOR CONSUME ALCOHOLIC BEVERAGES WHILE UNDER THE EFFECTS OF MEDICATION GIVEN TO ME FOR USE DURING OR FOLLOWING THIS PROCEDURE.

IF ANY UNFORSEEN CONDITION ARISES 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 PATIENT DIFFERENCES RESULT IN THE RISK OF FAILURE, 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.

**PLANNED PROCEDURE** \_\_\_\_\_

**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.**

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**DATE PATIENT, PARENT, OR GUARDIAN**

\_\_\_\_\_ **WITNESS**

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