CONSENT FOR ORAL SURGERY

I, ____, hereby authorize and direct the doctor with the assistant(s) of his/her choice to perform the following surgical procedure: ____, including necessary or advisable anesthesia and medications. This operation has been explained to me. Alternative treatments, if any, have also been explained to me, as have the advantages and disadvantages of each. I understand that there are certain potential risks in any treatment plan or procedure, and that in this instance such operative risks include but are not limited to:

1. Postoperative discomfort and/or swelling that may necessitate several days of home recuperation.
2. Heavy bleeding that may be prolonged.
3. Bruising of the face (which is due to bleeding within the tissue, in which blood pigment works its way to the skin surface).
4. Failure of the surgical area to heal.
5. Injury to adjacent teeth, fillings, crowns and/or hard or soft tissue.
6. Postoperative infection requiring additional treatment.
7. Fracture of the jaw.
8. Restricted mouth opening for several days or weeks, partly due to stress on the jaw joints (TMJs).
9. Existing TMJ problems may be worsened.
10. Decision to leave a small piece of root in jaw, when its removal would require extensive surgery and higher risk.
11. Injury to the nerve underlying the teeth, resulting in numbness or tingling of the chin, lip, cheek, gum, and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.

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12. Breakage of an instrument or bur tip, resulting in swallowing or aspirating (inhaling) the tip, possibly requiring medical treatment.
13. Opening of the sinus (a normal cavity situated above the upper teeth), requiring additional post-operative precautions, medications, or surgery.
14. Allergic reactions (previously unknown) to any of the medications used.
15. "Dry socket," requiring additional treatment visits.

If any unforeseen condition should arise in the course of the procedure, calling for the doctor's judgment or for procedures different from those now contemplated, I request and authorize the doctor to do whatever he/she may deem advisable.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. However, it is the doctor's opinion that treatment would be helpful, and that worsening of my condition would occur sooner without the recommended treatment.

I agree to cooperate completely with the recommendations of the doctor(s), while I am under their care, realizing that any lack of the same could cause a less than optimum result.

I CERTIFY THAT I HAVE HAD AN OPPORTUINITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO TREATMENT, AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN BEFORE I SIGNED.

_____________________________________ __________________________

Patient's or Guardian's Signature Date

__________________________________ __________________________________

Witness's Signature Doctor's Signature