Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your condition and the recommended treatment plan so that you may make an educated 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 provide information so that you may give or withhold your consent.

_____1. My condition has been explained to me as: _____

_____2. The procedure(s) necessary to treat the condition(s) has/have been explained to me and I understand the nature of the treatment to be: _____
_____

_____3. I have been informed of possible alternate methods of treatment (if any), including:_____

I understand that these other forms of treatment, or no treatment at all, are choices that I have and the risks of those choices have been presented to me.

_____4. The doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment and in this specific instance they include, but are not limited to:

A. Post-operative discomfort and swelling that may require several days of at-home recovery.
B. Prolonged or heavy bleeding that may require additional treatment.
C. Injury or damage to adjacent teeth or fillings.
D. Post-operative infection that may require additional treatment.
E. Stretching of the corners of the mouth that may cause cracking or bruising, and may heal slowly.
F. 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.
G. A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
H. Fracture of the jaw (usually only in more complicated extractions or surgery).
I. Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums or tongue and which may persist for several weeks, months or, in rare instances, permanently.

J. Opening of the sinus (a normal chamber situated above the upper teeth) requiring additional surgery or treatment.
K. Dry socket (loss of blood clot from extraction site).
L. Allergic reactions (previously unknown) to any medications used in treatment.

_____5. It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph 2 above. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

_____6. **ANESTHESIA**
The anesthetic I have chosen for my surgery is:
Local Anesthesia
Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
Local Anesthesia with Oral Premedication
Local Anesthesia with Intravenous Sedation
General Anesthesia

_____7. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, does carry with it the rare risks of heart irregularities, heart attack, stroke, brain damage or even death.

_____8. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**
Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. **TO DO OTHERWISE MAY BE LIFE-THREATENING!**
However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water.**

_____9. It has been explained to me, and I fully understand, that a perfect result is not or cannot be guaranteed.

INFORMATION FOR FEMALE PATIENTS

_____1. I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

CONSENT

I certify that I speak, read and write English and have read and fully understand this consent for surgery, have had my questions answered and that all blanks were filled in prior to my initials or signature.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date