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Comprehensive Family Dentistry

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INFORMED CONSENT TO PERFORM ORAL SURGERY

I have been given a diagnosis based on the information gained by clinical exam of:

_____.

I have been advised that the consequences of not treating this condition include but are not limited to: infection, swelling, pain, periodontal disease, malocclusion, fracture of the jaw, and/or loss of bone. Impacted wisdom teeth are subject to and responsible for infections, cysts and tumors, cavities, pressure damage and periodontal damage to normal teeth, gum, and bone. These complications may cause pain, destroy jawbone and teeth, and adversely affect overall health. Alternative treatments include but are not limited to:

I, the undersigned, give permission and consent to perform the following procedure(s):

_____ and understand that certain risks and consequences exist which include but are not limited to:

1. Post-operatively I can expect some pain, swelling, discoloration of the face, and/or bleeding. Swelling may occur for several days after surgery. Recuperation may require several days at home.
2. Local anesthetic reactions may occur. Although rare this could include numbness, swelling, pain, infection, abnormal reactions or allergy and may adversely affect health. If you desire i.v. sedation or general anesthetic, or for any other reason we will refer you to an oral surgeon.
3. Numbness may occur in the region of surgery, gums, lip, or tongue. This is usually a temporary condition, but some cases may be permanent.
4. A dry socket (poor healing of the socket) may occur. A dry socket is painful and requires frequent treatment at the office.
5. Root tips sometimes break off in the bone and may be left to avoid extensive surgery. With upper teeth the root tips sometimes expose or are pushed into the maxillary sinus.
6. Infection is uncommon but may occur. Antibiotics may be needed post-operatively.
7. Fracture of the bone may occur.
8. Damage to adjacent teeth or restorations may occur.
9. Temporomandibular joint dysfunction (the jaw joint may not function well) may occur.
10. Any complications will be treated here or you will be referred to the appropriate specialist if additional treatment is needed. Treatment may consist of physical therapy, antibiotics or other drugs, or additional surgery.

I am aware that the practice of Dentistry is not an exact science, that the very nature of the treatment and my uniqueness as an individual require that no predictions can be made. I acknowledge that no guarantees have been made to me. I believe it is in my best interest to proceed with my chosen treatment, as opposed to any alternatives which may exist. I have had ample opportunity to ask questions I might have and have had them answered to my satisfaction. I agree to abide by the doctor's post-operative instructions and that my failure to properly care for my oral health may lead to further complications. I have had the opportunity to discuss with the doctor my overall health and medical history. I accept the risks of subsequent harms, if any, in hopes of obtaining the desired beneficial results of this treatment.

The risks involved with anesthesia and the treatment itself have been fully explained to me and I do give my free and voluntary informed consent to same.

Signature of Patient or person authorized to consent for patient

Date

Witness

Date