

INFORMATIONAL USE ONLY

CONSENT FOR ORAL SURGERY

A. RECOMMENDED TREATMENT

I give permission to Dr. _____ to perform the following treatment as well as any additional procedures considered necessary on the basis of findings during the actual surgery. This permission is for myself (or my ward or minor child) named below. I fully understand this consent for surgery and the reasons why the recommended treatment is necessary. I have been given the opportunity to ask questions regarding the recommended treatment and have been given satisfactory answers. I understand that no guarantee regarding the treatment has been made or implied.

TREATMENT: _____

B. TREATMENT ALTERNATIVES

I elected the treatment listed above even though the following alternatives have been explained to me as being both practical and possible.

TREATMENT ALTERNATIVES: _____

C. ANESTHESIA/MEDICATIONS

I also authorize the recommended treatment to be performed with the following anesthetics and/or medications:

- Local anesthesia only
- Local anesthesia with nitrous oxide and oxygen

D. RISKS AND CONSEQUENCES

I understand that there are risks associated with the administration of medications and performance of the recommended surgery such as the items check below:

- Drug reactions and side effects
- Post-operative bleeding and pain
- Necessary removal of bone during tooth extraction
- Post-operative infection or bone inflammation
- Possible damage to the sinus when upper back teeth are removed which may require surgical repair at a future date
- Possible nerve damage when lower wisdom teeth are removed which can result in either temporary or permanent tingling or numbness in the lower lip
- Fracture of the mandible
- Jaw joint (TMJ) pain, malfunction and/or difficulty in opening mouth due to muscle spasms, following removal of lower teeth

Date

Patient or Patient's Guardian

Date

Witness