INFORMATIONAL PURPOSES ONLY

CONSENT FOR ORAL SURGERY

Patient's Name: _____ Age: _____

I hereby give consent to Dr. _____ to perform the oral surgery procedure(s) for myself or my dependent as follows: .....
.....
and such additional procedures as are considered necessary for my well being on the basis of findings during the course of said procedure(s). The nature and purpose of the procedure have been explained to me and no guarantee has been made or implied as to result or cure.

Alternative methods of treatment have been explained to me, such as: .....
.....
but I desire the treatment described above.

I also consent to the administration of local anesthesia and the taking of any radiographs (x-rays) as indicated.

I understand that the administration of medications and the performance of surgery can carry certain common, inherent risks, or complications such as, but not limited to: bleeding; swelling; discomfort; nausea; infection; drug reaction; delayed healing; damage to other teeth or restorations; bone fractures; and possible involvement of the nerve that could result in a usually temporary, but possibly permanent, numbness or tingling in the lower lip.

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.

Signed: _____ Date: _____

Relationship (to minor): _____

Witness (to signature only): _____

I acknowledge the receipt of, and understand my post-operative instructions.

Patient's initials: _____

Patient's Name: _____ Age: _____