INFORMATIONAL USE ONLY

SURGICAL INFORMED CONSENT

I hereby give permission to Dr. _____ to treat me (or my dependent _____) and authorize the following procedure or such additional procedures as are considered necessary on the basis of findings during the course of said procedure:

_____
_____
_____

The following reasons are why the above named surgery is considered appropriate: _____
_____
_____

The following alternative treatment methods have been explained to me: _____
_____
_____

I have also been advised as to the probable outcome if no treatment is provided for this condition.

I consent to the following anesthesia and/or medications to be given at the time of surgery:

1. Local anesthesia
2. Local anesthesia with nitrous oxide/oxygen
3. Local anesthesia with nitrous oxide/oxygen and intravenous sedation

I understand there are certain common inherent risks possibly associated with this surgery and anesthesia including but not limited to:

1. Drug reactions and side effects
2. Post-operative bleeding, swelling, bruising, pain and discomfort
3. Post-operative nausea, weakness and possibly loss of time from work or school
4. Post-operative infection, delayed healing, bone inflamation
5. Sinus involvement possibly requiring additional treatment or surgery
6. Nerve injury within the lower jaw resulting in temporary but possibly permanent numbness and/or tingling of the lower lip, gums, or jaw
7. Bone fracture
8. Bruising or inflamation at the site of the intravenous injection

I understand the risks of driving, operating hazardous equipment, and drinking alcohol while recovering from anesthesia and while taking prescribed pain medication. I have been given the opportunity to ask questions regarding this treatment to clarify by understanding.

I am aware that the practice of oral surgery in not an exact science and I acknowledge that no guarantees have been made to me with regard to the procedures listed above.

_____ _____
Date (Signature of patient or person with authority to consent for patient)

_____ _____
Date (Dentist)

_____ _____
Date (Witness)