

## CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY

You have the right to be informed about your condition and the recommended treatment plan to enable you to make an educated decision as to whether or not to undergo the procedure(s). As with any type of surgery there are some risks involved.

**(Please initial each paragraph after reading. If you have any questions, please ask your doctor before initialing)**

\_\_\_1. My condition(s) has/have 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 treatment, or no treatment at all, are choices that I have and the risks of those choices have been presented to me.

\_\_\_4. My doctor has explained to me that there are certain inherent and potential risks and side effects associated with the proposed treatment(s) and in this specific instance, they include, but are not limited to:

- \_\_\_A. Post-operative discomfort and swelling which may require additional treatment.
- \_\_\_B. Prolonged or heavy bleeding, which 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 which may cause cracking or bruising, and may be slow to heal.
- \_\_\_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 small piece of root in the jaw may be left if its removal would require extensive surgery or risks of other complications.
- \_\_\_H. Fracture of the jaw (usually only in more complicated extractions or surgery).
- \_\_\_I. Injury to the nerve underlying lower teeth, resulting I pain, numbness, tingling, or other sensory disturbances in the chin, lip, cheek, gums, or tongue which may persist for several weeks, months, or in a instances, permanently.
- \_\_\_J. Opening of the sinus (chamber situated above the upper teeth) requiring additional surgery or treatment,
- \_\_\_K. Dry socket or loss of blood clot from the extraction site.
- \_\_\_H. 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 item 2 above. In this instance, I authorize my doctor and staff to use professional judgment to perform additional procedures the deem necessary and desirable to complete my surgery.

\_\_\_6. The anesthetic I have chosen for my surgery is:

- Local Anesthesia w/ oral premedication
- Local Anesthesia w/ Nitrous Oxide/Oxygen Analgesia
- Local with Intravenous (IV) Sedation
- Local Anesthesia
- General Anesthesia

\_\_\_7. **ANESTHETIC RISKS** includes: discomfort, swelling, bruising, infection, prolonged numbness, or dizziness, nausea, and all 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 OBLIGATION IF IV ANESTHIA IS USED**

- A. since anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you have sufficiently recovered to care for yourself. This may take up to 24 hours.
- B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
- C. Prior to the procedure you must have a completely empty stomach. **THIS IS IMPORTANT THAT YOU HAVE NOTHING TO EAT OR DRINK FOR 8 HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE TREATENING.**
- D. However, if you are taking any regular medications (e.g high blood pressure, antibiotics, etc.) it is **IMPORTANT** that you take these medications or any medications provided by this office, by usin only a small cup of water.

\_\_\_9. It has been explained to me, and I fully understand that a perfect result is not or cannot be guaranteed.

\_\_\_10. I certify that I speak, read and write English and read and fully understand this consent for surgery. I have had my questions answered by my doctor or his/her staff and that all blanks were filled in prior to my initial signature.

PLEASE ASK THE DOCTOR OR ANY OF THE STAFF IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT FORM.

I herby acknowledge that I have read the foregoing, have discussed any questions or concerns I may have regarding my proposed treatment, and that I have received a copy of this form.

Patient's (or authorized guardian) signature X\_\_\_\_\_ Date\_\_\_\_\_

If authorized guardian, relationship to patient:\_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date\_\_\_\_\_

Witness \_\_\_\_\_ Date\_\_\_\_\_