oral surgery

patient consent form

I, _____, hereby authorize Dr. _____ to perform oral surgery.
(Patient Name) (Dentist Name)

I understand that this surgery is:

- an **elective/non-urgent** procedure _____

OR (initial beside the procedure type)

- an **urgent/emergency** procedure _____

I have been informed that the risks to my health if this procedure is not performed include but are not limited to: pain, infection, cyst formation, loss of bone around teeth causing their loss, and an increased risk of complications if surgery is postponed.

I have been informed of any possible alternative methods of treatment should any exist. Furthermore, I understand that there are certain inherent and potential risks in any treatment or procedure, an that in this specific instance, such risks may include the following:

Common Concerns

- Postoperative discomfort and swelling that may necessitate several days of home recuperation
- Restricted mouth opening for several days or weeks
- Dry socket
- Prolonged bleeding
- Postoperative infection requiring additional treatment
- Prolonged drowsiness
- Nausea and vomiting (usually associated with medications prescribed for pain)

Exceptional Occurrences

- Decision to leave a small piece of root in the jaw when removal would require extensive surgery
- Damage to adjacent teeth, fillings, and crowns
- Stretching of the corners of the mouth with resulting cracking and bruising
- Opening into the maxillary nasal sinus or nose requiring additional surgery
- Fracture of the jaw
- Change in occlusion and temporal-mandibular joint difficulty including bite differences and jaw discomfort
- Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side. This may persist for several weeks, months, or in remote instances be permanent.

Additional Concerns

- _____

_____

I consent to the administration of **local anesthesia** (ie. **Novacaine**), **intravenous sedation (IV)**, **nitrous oxide analgesia** or **oral sedation** in connection to the procedure referred to above.

I certify that I have read this consent in its entirety and fully understand its contents, all associated risks, and that a perfect result will not be guaranteed. If unexpected problems arise during the procedure, the doctor has my permission to do what is deemed necessary to correct the condition.

Drugs given at the time of surgery for sedative purposes or control of pain following the surgery may cause drowsiness and a lack of awareness or coordination. I have been advised to have an escort for these reasons. If instructed not to do so, I will not drive or perform hazardous chores until I have recovered from the effects of these medicines.

Procedure Details as noted by DDS:

CONSENT and AUTHORIZATIONS

Patient Name (Printed)

Providing Dentist's Name (Printed)

Signature of Patient/Legal Guardian

Signature of Providing Dentist

Date

Date

Additional Remarks, per DDS:

Name of Witness or Interpreter

Signature of Witness or Interpreter

Please call us if you experience prolonged bleeding, persistent pain, or have any questions or concerns during the healing process.
We are always here to help.

ADMIN USE ONLY:
Scanned to Records Manager