

ORAL SURGERY CONSENT FORM

The incidence of complications associated with oral surgery is very low, but anyone undergoing any surgical procedure is entitled to know of the possible hazards and complications, which may be, result from surgery. This information is being supplied prior to obtaining your permission for surgery.

The procedure(s) necessary to treat my condition(s) have been explained to me and I understand the nature of the procedure to be:

I understand that this is an elective procedure and other forms of treatment or no treatment are the choices I also have, which have been explained to me by the doctor. The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to the following:

1. Post-operative discomfort and swelling that may necessitate several days of recuperation.
2. Heavy bleeding that may be prolonged.
3. Post-operative infection requiring additional treatment.
4. Restricted mouth opening for several days or weeks.
5. Injury to adjacent teeth and fillings.
6. Decision to leave a small piece of root in the jaw.
7. Breakage of the jaw.
8. Injury to the temporomandibular joints, possibly including limited function and pain.
9. With surgery and extractions of the lower jaw, injury to the nerve underlying the teeth resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances, permanently.
10. With surgery and extractions of the upper jaw, an opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
11. Cardiac arrest.
12. Other: _____

I certify that I have read and fully understand this consent for surgery.

PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

Patient, Parent or Guardian

Date _____

Witness

Date _____

Doctor

Date _____