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CONSENT FOR ORAL SURGERY

Patient Name: _____

Treatment to be done: _____

This consent is designed for and intended to assist you in making an educated decision involving your dental care. Extraction of teeth is an irreversible process and, whether routine or difficult, is a surgical procedure. As in any surgery, there are some risks. These risks include, but are not limited to:

___ The risks of using local anesthetic include dizziness, nausea, vomiting, accelerated heart rate, slow heart rate or various types of allergic reactions. Any of these may require additional medical treatment.

___ Local anesthetic can also cause prolonged numbness that can result in injury due to biting the tissues of the lip, tongue, or cheek. This may persist beyond the normal recovery time and may, although rare, become permanent.

___ Difficulty in opening of your mouth after treatment. This can be related to tenderness in the muscles of the jaw at the site of the injections. It can also be caused by straining the muscle due to the length of the procedure.

___ Swelling and/or bruising and discomfort in surgery area.

___ Possible infection following surgery requiring further treatment.

___ Dry socket - jaw pain beginning a few days following surgery requiring further treatment. (It is more common in lower teeth and wisdom teeth, but can happen anywhere)

___ Trismus. This is limited jaw opening due to swelling. This can especially happen when TMJ symptoms already exist.

___ Incomplete removal of root tip(s) and/or bone fragments. Sharp splinters of bone can work their way to the surface later and may cause discomfort.

___ Slight bleeding or oozing is normal after surgery. Heavy bleeding is not common but can occur. Further treatment may be required if this happens.

___ Other complications, although rare, can occur. These include, but are not limited to jaw fracture, instrument fracture in which a small piece may be left in extraction site or even swallowed, or damage to adjacent teeth and/or gum tissue.

The following treatment is recommended:

The alternative treatment for you is:

I understand the risks and the benefits associated with this treatment. I have been given alternative treatment options and I understand the recommended treatment.

I give my consent for Dr. Gregory Garrett to extract tooth number(s) _____.

I agree to the use of local anesthetics as deemed necessary by Dr. Garrett.

I have had the financial aspect of this treatment and the follow-up restorative treatment explained to me and I take full financial responsibility for it. I understand that payment is due in full at or before treatment is rendered. (Unless prior arrangements have been made in writing).

ALL SIGNATURES MUST BE BY A PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE.

Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Witness Signature: _____ Date: _____