ORAL AND MAXILLOFACIAL SURGERY CONSENT FORM

Dear Patient:

You have a right to be informed about your diagnosis and planned surgery so that you may make a decision whether to undergo a procedure after knowing the risks. This disclosure is not meant to frighten or alarm you. It is simply an effort to better inform you so that you may give your informed consent to the procedure.

POSSIBLE COMPLICATIONS OF:

1. ALL SURGERIES

A. Soreness, swelling, bruising and 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.

B. Bleeding, usually controllable, but may be prolonged and require additional care.

C. Drug reaction or allergies.

D. Infection, possibly requiring additional care.

2. ALL TOOTH EXTRACTIONS

A. Dry Socket (discomfort occurring a few days after extractions, requiring additional care)

B. Osteonecrosis of the jaw – failure of the bone to heal properly, especially with bisphosphonate use.

C. Damage to adjacent teeth, fillings or crowns.

D. Sharp ridges or bone splinters: may require additional surgery to smooth area.

E. Portions of a tooth remaining: sometimes fine root tips break off and may be deliberately left in place to avoid causing damage to nearby vital structures such as nerves or sinuses.

3. LOWER TEETH

A. NUMBNESS: Due to the proximity of the roots to the nerve (especially lower wisdom teeth) it is possible to injure the nerve during removal of the tooth. The lip, chin, gums, tongue or cheek could thus feel numb (resembling local anesthetic injection). This could remain for days, weeks or rarely, permanently.

4. UPPER TEETH

A. SINUS INVOLVEMENT: Due to the closeness of the roots of the upper back teeth to the sinus, or from a root tip being displaced into the sinus, a possible sinus infection and/or sinus opening may result, which may require medication and/or later surgery to correct.

5. ANESTHESIA

A. LOCAL ANESTHESIA: Although rare, certain possible risks exist. These include: pain; swelling; bruising; infection; nerve damage; and unexpected allergic reactions, which could result in heart attack, stroke, brain damage and/or death.

PATIENT NAME_____

I hereby authorize Dr._____and staff to perform the following procedure(s):

_____

and to administer local anesthesia. I have been given alternatives to this treatment, including no treatment. I understand that my dentist may find other conditions that may require additional or different procedures than planned. I authorize him/her to perform such as he/she deems necessary in order to complete my surgery. I have been read and discussed the preceding and believe I have been given sufficient information to give my consent to the planned surgery.

PATIENT OR LEGAL GUARDIAN_____DATE_____

WITNESS _____DATE_____

DOCTOR_____DATE_____

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