CONSENT FORM FOR SURGICAL TOOTH EXTRACTIONS AND RELATED SURGERY

<u>Instructions to Patient</u>: Please take this document home and read it carefully. Note any questions you might have in the area provided in Paragraph 12. Bring this back to our office at your next appointment and the doctor will review it with you before you sign it.

1. My dentist has recommended the following procedures:

   _____

   _____

   _____

2. I have been informed of the risks and complications of the recommended oral surgical procedures, anesthesia, and the proposed drugs including, but not limited to, pain, infection, swelling, heavy or prolonged bleeding, discoloration, numbness and tingling of the lip, tongue, chin, gums, cheeks and teeth; pain, numbness and phlebitis (inflammation of a vein) from an intravenous and/or intermuscular injection; injury to and stiffening of the neck and facial muscles; malfunction of the adjacent facial muscles for an indefinite time; change in occlusion or temporomandibular (jaw) joint difficulty; or injury to adjacent teeth or restorations in other teeth, or injury to adjacent soft tissues.

3. I have further been informed of other potential complications including, but not limited to, nausea, vomiting, allergic reaction, bone fractures, bruises, delayed healing, sinus complications, openings from the sinus into the mouth, apparent facial changes, nasal changes, the possibility of secondary surgical procedures, loss of bone and the invested teeth, non-healing of the bony segments, devitalization (nerve damage which may require a root canal) of teeth and relapse.

4. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of this procedure, the associated treatment and procedures, or the post-surgical dental procedures. I am further aware that there is a risk of failure and/or further corrective surgery may be necessary. Such a failure and remedial procedures may involve additional fees being assessed.

5. I agree and understand I am not to have anything to eat for ___ hours before my surgery.

6. I authorize Dr. _____ to perform the recommended dental procedures. I agree to the type of anesthesia that he/she has discussed with me, specifically (local) (IV sedation) or (general). I agree not to operate a motor vehicle or hazardous device for at least twenty-four (24) hours after the procedure or until fully recovered from the effects of the anesthesia or drugs given for my care. I

agree not to drive home after my surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

7. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated and I am under general anesthesia or IV sedation, I further authorize and direct Dr. _____, his/her associates or assistants of his/her choice, to do whatever he/she/they deem necessary and advisable under the circumstances, including the decision not to proceed with the surgical procedure.

8. I agree to cooperate with the post-operative instructions of my dentist, realizing that any deviation from the instructions or lack of cooperation could result in less than optimum result. I further agree that if I do not follow my dentist's recommendations and advice for post-operative care, my dentist may terminate the dentist-patient relationship, requiring me to seek treatment from another dentist.

9. To my knowledge, I have given an accurate report of my health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my health or any problems experienced with any prior medical, dental or other health care and treatment.

10. The fee for services has been explained to me and is acceptable, and I understand that there is no warranty or guarantee as to the result of this treatment.

11. I realize and understand that the purpose of this document is to evidence the fact that I am knowingly consenting to the oral surgical procedures recommended by my dentist.

12. Questions I have to ask my dentist _____
_____
_____
_____
_____
_____

13. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION AND INFORMED CONSENT TO THIS PROCEDURE AND THAT ALL OF MY QUESTIONS, IF ANY, HAVE BEEN ANSWERED. I HAVE HAD THE OPPORTUNITY TO TAKE THIS FORM HOME AND REVIEW IT BEFORE SIGNING IT.

_____	_____
Patient, Parent or Guardian	Date
_____	_____
Dentist	Date
_____	_____
Witness	Date
_____	_____
Witness	Date