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Oral Surgery Informed Consent Form

My dentist has recommended the following procedures:

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_____

_____

I, _____understand that oral surgery is a treatment performed to remove a tooth/teeth or oral tissue. I have been informed of possible alternative treatment methods including waiting for a more definitive development of symptoms, and possible periodontal and/or endodontic treatment with subsequent restoration options.
Certain procedural complications and/or side effects and risks may be associated in this specific instance, including, but not be limited to:

- Post-operative discomfort and swelling that may require several days of at-home recovery.
- Prolonged or heavy bleeding that may require additional treatment.
- Injury or damage to existing teeth or their dental restorations
- Restricted mouth opening during healing (sometimes related to stress on the jaw joints TMJ, especially when TMJ problems already exist.
- Fracture of the jaw.
- Injury to the nerve underlying the lower teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, teeth, gum or tongue and which may persist for several weeks or months or in rare instances, permanently.
- Opening into the sinus (a normal chamber situated above the upper teeth) or displacement of a tooth root into the sinus, requiring additional surgical treatment.
- Sharp ridges or bone splinters may form later at the edge of the socket; these may require another surgery to smooth or remove.
- Incomplete removal of tooth fragments; to avoid injury to vital structures such as nerve or sinus, sometimes small root tips may be left in place.
- Allergic reaction (previously unknown) to any medications in the treatment

Additionally, I have been informed that during the course of treatment, unforeseen conditions may be revealed that may require changes in the procedure noted below. I authorize the providing doctor to use his professional judgment and perform such additional procedures that are necessary to complete my surgery.

I acknowledge full responsibility for the payment of such services and agree to pay them in full at or before completion, unless specific arrangements are made with our business office staff.

For female patients on birth control pills: I have been advised that certain antibiotics and other medications may neutralize the prevention effect of birth control pills, allowing for conception and pregnancy. I understand I need to initiate additional forms of birth control during the period of my treatment and to continue those methods until the next full birth control pill cycle.

Patient's signature_____ Date_____
(Legal guardian if minor)

Doctor's signature_____ Assistant initials_____