Consent for Oral and Maxillofacial Surgery

Patient's Name _____ _____
DATE

PLEASE READ AND INITIAL EACH PARAGRAPH BELOW. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING OR SIGNING THIS FORM.

You have the right to be informed about your condition and the risks and hazards involved with the recommended treatment plan to make an educated decision as to whether to undergo the procedure. This disclosure is not meant to alarm you but is instead an effort to provide information so that you may give or withhold your consent.

x 1. My condition has been explained to me as o Insufficient arch space o cavities o difficult to maintain hygiene o #1 (upper right) o #16 (upper left) o #17 (lower left) o #32 (lower right)

x 2. The procedure(s) necessary to treat the condition(s) has/have been explained to me and I understand the nature of the treatment to be

Extraction of o #1 o #16 o #17 o #32

x 3. I have been informed of possible alternative methods of treatment (if any), including

No treatment

I understand that these other forms of treatment, or no treatment at all, are choices that I have, and the risks of those choices have been presented to me.

x 4. My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment, which include, but are not limited to,

a. Postoperative discomfort and swelling that may require several days of at-home recovery.
b. Prolonged or heavy bleeding that may require additional treatment.
c. Injury or damage to adjacent teeth or fillings.
d. Postoperative infection that may require additional treatment.
e. Stretching of the corners of the mouth may cause cracking or bruising, and may heal slowly.
f. Restricted mouth opening during healing; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints, temporomandibular joint (TMJ), especially when TMJ problems already exist.
g. A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
h. Fracture of the jaw (usually only in more complicated extractions or surgery).
i. Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums or tongue that may persist for several weeks, months or, in rare instances, permanently.
j. Opening of the sinus (a normal chamber situated above the upper teeth), requiring additional surgery or treatment.
k. Dry socket (loss of blood clot from extraction site).
l. Allergic reactions (previously unknown) to any medications used in treatment.

x 5. It has been explained that during treatment, unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph 2 above. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

x 6. **Anesthesia**

The anesthesia I have chosen for my surgery is

_____ Local Anesthesia
_____ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
_____ Local Anesthesia with Oral Premedication
__X__ Local Anesthesia with Intravenous Sedation
_____ General Anesthesia

x 7. **Anesthetic Risks** include discomfort, swelling, bruising, infection, prolonged numbness, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) that may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries the rare risks of heart irregularities, heart attack, stroke, brain damage, or even death.

x 8. **Your Obligations If IV Anesthesia Is Used**

a. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. Recovery period may be up to 24 hours.

b. During recovery time (24 hours), you should not drive, operate complicated machinery or devices, or make important decisions (such as signing documents).

c. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC.
TO DO OTHERWISE MAY BE LIFE-THREATENING!

d. **It is important** that you take any regular medications (e.g., high-blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water.**

e. The administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of practitioner, the age and health of the patient, and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your child's anesthesia for his or her dental treatment, and consult with your dentist or pediatrician as needed.

x 9. It has been explained to me and I fully understand, that a perfect result is not or cannot be guaranteed.

x 10. **Opioid Risks**

a. If you or your minor are being prescribed a controlled substance containing an opioid for postoperative pain control the risks of addiction and overdose associated with controlled substances containing opioids have been discussed. Controlled substance are those that have been identified by the United States Drug Enforcement Administration as having a potential for abuse, dependence or misuse.

b. There is an increased risk of addiction to controlled substances in individuals suffering from mental or substance abuse disorders.

c. There is an increased risk of death or overdose when taking a controlled substance containing opioids with benzodiazepines, alcohol, or other central nervous system depressants.

d. Your provider has discussed these risks and you have had the opportunity to ask any questions regarding the controlled substance you are being prescribed.

INFORMATION FOR FEMALE PATIENTS

x I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the effectiveness of birth control pills, causing pregnancy. I agree to consult with my physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my physician that I can return to the use of oral contraception.

CONSENT

I certify that I have read and fully understand this consent for surgery, have had my questions answered, and that all blanks were filled in prior to my initials or signature.

X _____ _____

PATIENT'S/LEGAL GUARDIAN'S SIGNATURE DATE

X _____ _____

DOCTOR'S SIGNATURE DATE

X _____ _____

WITNESS' SIGNATURE DATE