FAMILY, IMPLANT & COSMETIC DENTISTRY

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INFORMED CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY

Procedure: Surgical removal (extraction) of wisdom teeth or other teeth.

Alternatives to Surgery: Risks to my health if these teeth are not removed include, but are not limited to:

1. Infection
2. Cyst or tumor formation
3. Periodontal (gum) disease
4. Increased risk for complications if removal is required at a later time.

Possible complications which have been discussed with me include, but are not limited to:

1. Injury to the nerves to the lower lip and tongue causing numbness, which could possibly be permanent.
2. Bleeding and/or bruising which may be prolonged.
3. Dry socket
4. Involvement of the sinus above the upper teeth.
5. Infection
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and increase risk of complications.
7. Injury to adjacent teeth or fillings.
8. Unusual reaction to medications given or prescribed.
9. Jaw bone fracture.
10. Trismus (jaw stiffness) or injury to the temporomandibular joints.
11. Small bone fragments or bone graft particles (if a graft is performed) may exude from the socket.
12. _____

Anesthesia: I may receive nitrous oxide (laughing gas) or another sedative to make the surgery more comfortable. I have someone to drive me home and understand that I may be sleepy or drowsy for several hours. I will not drive or perform hazardous chores until fully recovered from the anesthetic.

I understand that a perfect result cannot be guaranteed. If any unforeseen conditions arise during the procedure, I request and authorize the doctor to do whatever he deems advisable to correct the condition.

I agree to cooperate completely with the doctor and will follow post-operative instructions to the best of my ability for my own comfort and safety. I have had the opportunity to ask questions concerning these procedures.

_____ _____

Patient, Parent or Guardian Date

_____ _____

Doctor Witness