Consent for Oral Surgery

Patient Name: _____
Date of Birth: _____
I hereby authorize Dr. _____ to perform the following treatment or surgical procedure: _____, and I understand that it is an **elective**/**urgent**/**emergency** procedure (circle one).

I have been informed that the risks to my health if this procedure is not performed include, but are not limited to pain, infection, cyst formation, loss of bone around teeth causing their loss, and an increased risk of complications if surgery is postponed.

I have been informed of any possible alternative methods of treatment should any exist. Further, I understand that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance such risks may include the following:

1. Postoperative discomfort and swelling that my necessitate several days of home recuperation
2. Restricted mouth opening for several days or weeks
3. Prolonged bleeding
4. Nausea and vomiting (usually associated with medications prescribed for pain)
5. Postoperative infection requiring additional treatment
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery
7. Damage to adjacent teeth, fillings, and crowns
8. Stretching of the corners of the mouth with resulting cracking and bruising
9. Opening into the maxillary sinus or nose requiring additional surgery
10. Prolonged drowsiness, weakness, sense of malaise
11. Change in occlusion and temporal-mandibular joint difficulty
12. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months, or in remote instances, be permanent
13. Fracture of the jaw
14. Additional complications:

( ) I consent to the administration of local anesthetic (eg. lidocaine), Intravenous (IV), nitrous oxide analgesia, or oral sedation in connection to the procedure referred to above (circle all the apply).

I certify that I have read the above and fully understand this consent for surgery, and that I understand that a perfect result **cannot be guaranteed**. If unexpected problems arise during the procedure, the doctor has my permission to do what is deemed necessary to correct the condition.

Drugs given at the time of surgery for sedative purposes or control of pain following the surgery may cause drowsiness and a lack of awareness or coordination. If instructed to do so, I will not drive or perform hazardous chores until have recovered from the effects of these medications

Patient's Signature	Date
Parent or Legal Guardian (if patient under 18 years of age)	Date
Witness or Interpreter	Date
Dentist's Signature	Date