In-House Dental Care 9506 Hamilton Ave. Huntington Beach, CA 92646 P (949)339-5373 F (949)339-5383

# Consent for Oral Surgery

Patient Name_____ DOB: _____

Reponsible Party/Power of Attorney _____

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment.

The doctor has explained to me that there are certain potential risks in this treatment plan or procedure. These include:

1. Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums and/ or tongue on the operated side; this can persist for several weeks, months or, in rare instances, permanently
2. Postoperative infection requiring additional treatment
3. Opening of the sinus ( a normal cavity situated above the upper teeth) requiring additional surgery
4. Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular(jaw) joint
5. Injury to adjacent teeth and fillings
6. In rare circumstances, cardiac arrest or breakage of the jaw
7. Postoperative discomfort, swelling and bleeding that may necessitate several days of recuperation
8. A small piece of root left in the jaw when removal would require extensive surgery
9. Stretching of the corners of the mouth with resultant cracking and bruising
10. _____
    _____
    _____

Risk of Medication Related Osteonecrosis of the Jaw (MRONJ): I am initialing this section of the consent because the patient is taking or has taken medication known to cause osteonecrosis of the jaw. The risks, benefits, and alternatives have been explained to my full satisfaction. I understand that if the patient were to develop MRONJ, the patient would need to be seen by an oral and maxillofacial surgeon for treatment. **Initial(_____)**

Unforeseen conditions may arise during the procedure that requires a different procedure than set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgement, they are deemed necessary.

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs at the same time because it can increase these effects. I have been advised not to work and not to operate any vehicle, automobile or hazardous devices while taking such medications and until fully recovered from their effects.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

Consent for Treatment: I the undersigned, being the patient or responsible party for the patient, understand the aforementioned risks and treatment options. I authorize the extractions deemed to be advisable in the opinion of the dentist on the following teeth: _____

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

_____ _____

Patient/Responsible Party/Power of Attorney Signature Date