



Informed Consent for Oral Surgery

Name: _____ Today's Date: _____

Diagnosis: _____

Procedure: _____

Please initial beside each number.

1. _____ AUTHORIZATION: This is my consent for Dr. Johnson to perform the above outlined treatment/surgery as previously explained to me, and/or other procedures deemed necessary or advisable to complete the planned operation.

2. _____ TREATMENT: I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral and maxillofacial tissue. Dr. Johnson has advised me that if this condition persist(s) without treatment or surgery, my present oral condition will probably worsen in time, and the risks to my health may include but not be limited to the following:

swelling, pain, infection, cyst formation, periodontal (gum) disease, dental caries, malocclusion, pathologic fracture of the jaw, premature loss of teeth, and/or premature loss of bone, and possible hospitalization and extensive surgery. I have been informed of possible alternative methods of treatment, if any.

3. _____ RISKS: Dr. Johnson has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in specific instances such operative risks may include, but are not limited to:

- A. _____ Post operative discomfort and swelling that may necessitate several days of home recuperation.
- B. _____ Heavy bleeding which may be prolonged.
- C. _____ Injury to adjacent teeth, crowns or fillings.
- D. _____ Post operative infection requiring additional treatment.
- E. _____ Stretching of corners of the mouth with resultant cracking and bruising of lips.
- F. _____ Restricted mouth opening for several days.
- G. _____ Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and possible permanent damage to surrounding structures.
- H. _____ Breakage of the jaw.
- I. _____ Injury to a nerve underlying the tooth resulting in, but not limited to, partial or permanent numbness of the lips, chin, gums, cheek, teeth and/or tongue on the operated side, including loss of taste sensation.
- J. _____ Opening of a sinus (a normal cavity surrounding the roots of the **UPPER TEETH**) requiring additional surgery for correction.
- K. _____ Temporomandibular joint dysfunction (jaw joint) or jaw pain.
- L. _____ Other

(over)

