CONSENT FOR ORAL SURGERY AND ANESTHESIA
**** PLEASE INITIAL EACH PARAGRAPH AFTER READING ****
ASK YOUR DOCTOR ANY QUESTIONS YOU MAY HAVE

____ 1. **This is my consent for Dr. Brady, Dr. Simmonds-Brady, Dr. Loi and/or any Oral and Maxillofacial Surgeon working with them to perform the following treatment/procedure/surgery:**
_____
_____

____ 2. **I understand that the purpose of the treatment/procedure/surgery is to treat and possibly correct my diseased oral/maxillofacial tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present condition will probably worsen in time, and the risks to my health include but are not limited to: swelling, pain, infection, cyst formation, periodontal (gum) disease, dental carries, malocclusion, pathologic fracture of jaw, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.**

____ 3. **My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment and in this specific instance they include but are not limited to:**
*** post- operative discomfort and swelling that may require several days of stay at home recovery.**
*** prolonged or heavy bleeding that may require additional treatment.**
*** injury or damage to adjacent teeth or fillings.**
*** post-operative infection that may require additional treatment.**
*** stretching of the corners of the mouth that may cause cracking or bruising and may heal slowly.**
*** restricted mouth opening during healing; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ) especially when TMJ problems already exist.**
*** a decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.**
*** fracture of the jaw (usually only in more complicated extractions or surgery).**
*** injury to the nerve underlying teeth, resulting in pain, numbness, tingling, or other sensory disturbances in the chin, lip, cheek, gums, or tongue which may persist for several weeks, months, or in rare instances, permanently.**
*** temporary or sometimes permanent loss of taste.**
*** opening of the sinus (a normal chamber situated above upper teeth) requiring additional surgery or treatment.**
*** dry socket (loss of blood clot from extraction site).**
*** allergic reactions (previously unknown) to any medications used in treatment.**
*** non-healing exposed dead bone which may be the result of medications you take for osteoporosis, Cancer, or other bone diseases.**

____ 4. **It has been explained to me that during the course of treatment, unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph #1 above. I authorize my doctor and staff to use professional judgment to perform such additional procedures necessary and desirable to complete my surgery.**

____ 5. **ANESTHESIA**
The anesthesia I have chosen for my surgery is:
____ local anesthesia
____ local anesthesia with nitrous oxide
____ local anesthesia with intravenous sedation
____ general anesthesia

____ 6. Anesthetic risks include: discomfort, swelling, bruising, infection, prolonged numbness, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV sedation. Intravenous anesthesia and general anesthesia are serious medical procedures, and although considered safe, do carry with them the risks of heart irregularities, heart attack, stroke, brain damage, or even death.

____ 7. Patient obligations if IV sedation or general anesthesia is used

- *** 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. This may be up to 24 hours.**
- *** during recovery time, you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents.**
- *** you MUST have a COMPLETELY EMPTY STOMACH. It is vital that you have had NOTHING to eat or drink 6-8 hours prior to your anesthetic! To do otherwise may be life-threatening!**
- *** it is important however, to take your regular medications, or any medications provided by this office, using only a small sip of water.**

____ 8. It has been explained to me, and I fully understand that a perfect result is not or cannot be guaranteed. Due to individual patient differences, there exists a risk of failure, relapse, selective treatment, or worsening of my present condition despite the care provided.

____ 9. I understand that all teeth extracted during surgery will be immediately discarded into medical waste.

____ 10. I understand that all tissue removed for biopsy will be sent to the pathologist/lab of our choice.

____ 11. I have had an opportunity to discuss with my doctor my medical history including any past or current problems and/or injuries.

____ 12. I agree to fully cooperate with the recommendations of my doctor while I am under his/her care, realizing that any lack of cooperation could result in a less than optimum result.

____ 13. Information for female patients

I have informed my doctor about my use of birth control pills, shots, and/or patches. I have been advised that certain antibiotics and medications may neutralize the preventive effect of such birth control, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of my current birth control.

CONSENT

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

Patient's name	**Patient's (or legal guardian) signature**	**Date**
Witness' signature		**Date**
Doctor's signature		**Date**