Oral Surgery Informed Consent

I request and authorize Dr. Joiner or Dr. Zwart or their associates to perform the following oral surgery procedure upon me:

Procedure: _____

RISKS: I have been informed of and understand the potential risks related to this surgical procedure include but are not limited to:

- Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials;
- Nerve injury, which may occur from the surgical procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;
- Dry socket (slow healing) resulting in jaw pain that increases a few days after surgery;
- Sharp ridges or bone splinters may form where the tooth was removed possibly requiring additional surgery;
- Part of the tooth and/or roots may be left to prevent damage to nerves or other structures;
- An opening may occur from the mouth into the nasal or sinus cavities;
- Jaw fracture;

ANESTHSIA: I have elected to proceed with the anesthesia(s) indicated below and have been informed of and understand potential risks associated with anesthesia include but are not limited to:

_____ Local Anesthesia _____ Nitrous Oxide (Laughing Gas) _____ Mild Sedation

- Allergic or adverse reactions to medications or materials;
- Pain, swelling, redness, irritation, numbness and/or bruising in injection area. Usually the numbness or pain goes away, but in some cases, it may be permanent;

SOCKET PRESERVATION: Bone grafting is optional to preserve the amount of bone available for future implant placement, shape for bridge, or stability for a denture or partial denture.

_____ I choose to have the extraction socket preserved and/or grafted in the area.

_____ I choose NOT to have the extraction socket preserved and/or grafted in the area. This may reduce the option of dental implants in the future or affect the fit of dentures or partial dentures.

ALTERNATIVES: I have chosen to undergo this procedure after considering the alternative forms of treatment for my condition, which may include no treatment at all, root canal therapy, periodontal therapy or restorative options. Each of these alternative forms of treatment has its own potential benefits, risks and complications.

CONSENT: I certify that I have read or had read to me the contents of this form. I have read or had read to me and will follow any patient instructions related to this procedure. I understand the potential risks, complications and side effects involved with any dental treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____ _____ _____

Patient (Guardian) signature **Date** **Witness signature** **Date**