CONSENT FOR SURGERY AND ANESTHESIA

Patient: _____ Chart #: _____ Date: _____

This is my consent for Dr. _____ and/or any other oral and maxillofacial surgeon working with him/her to perform the following treatment/ procedure/ surgery:

_____

_____

as previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

I understand that the purpose of the 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 oral/ maxillofacial condition will probably worsen in time, and the risks to my health may include, but are not limited to the following: swelling, pain, infection, cyst or tumor formation, periodontal (gum) disease, dental caries, 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.

The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to:

1) Swelling, bruising and pain: These can occur with any surgery and vary from patient to patient and from one surgery to another.
2) Trismus: This is limited opening of the jaws due to inflammation and/ or swelling in the muscles. This is most common with impacted tooth removal but it is possible with any surgery.
3) Infection: This is possible with any surgical procedure and may require further surgery and/ or medications if it does occur.
4) Bleeding: Although significant bleeding can occur during or after surgery, it is not common. Some bleeding is, however, usual for most surgeries and is normally controlled by following the post-op instruction sheet.
5) Drug reactions: A reaction is possible from any medicaton given and could include nausea, rash, anaphylactic shock and/or death. It is now appreciated that antibiotics will inactivate most birth control pills. Sexually active women who take birth control pills should use another method of contraception for the remainder of the menstrual cycle if antibiotics are prescribed.
6) TMJ dysfunction: This means the jaw joint (temporomandibular joint) may not function properly and, although rare, may require treatment ranging from use of heat and rest to further surgery.
7) Reaction to local anesthetic: Certain possible risks exist that, although uncommon or rare, could include pain, swelling, bruising, infection, nerve damage, idiosyncratic or allergic reactions. In very rare and unpredictable cases the reactions to anesthesia medications can be life threatening.
8) Reaction to general anesthesia or sedation: Certain possible risks exist that, although uncommon or rare, could include hives, rashes, nausea, sweating and vomiting, pain, swelling, inflammation and/ or bruising at the injection site. Rare complications could include nerve damage to the arm, allergic or idiosyncratic drug reactions. In very rare and unpredictable cases the reactions to anesthesia medications can be life threatening.
9) Dry socket: This is significant pain in the jaw and ear due to loss of the blood clot and most commonly occurs after the removal of lower wisdom teeth, but is possible with any extraction. It occurs more frequently in patients who smoke after surgery. This may require additional office visits to treat.
10) Damage to other teeth and/or dental restorations: Due to the close proximity of the teeth, it is possible to damage other teeth and/or dental restorations when a tooth is removed.
11) Sharp ridges or bone splinters: Occasionally, after an extraction, the edge of the socket will be sharp or a bone splinter will come out through the gum. This may require another procedure to smooth the bone or remove the bone fragment.
12) Incomplete removal of tooth fragments: There are times the doctor may decide to leave a small fragment or root of a tooth in order to avoid damage to adjacent structures such as nerves, sinuses, etc., or when removal would require extensive further surgery.

13) Numbness: Due to the proximity of roots of lower teeth to the nerve, it is possible to bruise or damage the nerve with removal of a tooth. The lip, chin and/ or tongue could feel numb, tingling or have a burning sensation. This could remain for days, weeks, or very rarely, permanently.
14) Sinus involvement: Due to the location of the roots of the upper teeth to the sinus, it is possible that an opening may develop from the sinus to the mouth or that a root may be displaced into the sinus. A possible infection could develop and may require medication and/ or later surgery to correct.
15) Fracture of the jaw bone: On rare occasion, when the jaw bone has been weakened by preexisting conditions, the force required to remove a tooth may cause the bone to break. This may require further surgery to correct.
16) Stretching of the corners of the mouth with resultant cracking and bruising: This may occur due to retraction of the cheeks during surgery.
17) Other: _____

_____

I consent to administration of such local and/or general anesthesia or sedation as deemed necessary by the surgeon and/ or his designated assistants to accomplish the proposed procedure. Typically the effect of general anesthesia or sedation is described as being "asleep" during the surgery or procedure. The medications used generally cause amnesia (forgetfullness) of the surgery and the surrounding events. This amnesia is temporary. The doctor and treatment team are trained in the use of anesthesia and the treatment of complications. The patient's condition during anesthesia will be monitored by the doctor, staff, and by mechanical and electronic methods.

If I am having general anesthesia or intravenous sedation, I agree and understand that I am not to have and/or have not have anything to eat or drink for six hours before my surgery. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to operate any vehicle, automobile or hazardous device, make important decisions, or work, while taking such medications and/or drugs; or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least 24 hours after my release from surgery or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery. I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires a general anesthetic or sedative drug.

If any unforeseen condition should arise or findings be discovered in the course of the operation, calling for the doctor's judgement or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he may deem advisable. This includes sending tissues and/or fluids to an outside laboratory for examination, even if this had not been previously discussed.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective retreatment or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I have had an opportunity to discuss with my surgeon my past medical and health history including any serious problems and/or injuries. I certify that I have not omitted or concealed any significant facts regarding my past or present health.

I agree to cooperate completely with the recommendations of the doctor while I am under his care, realizing that any lack of same could result in a less than optimum result.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS, WORDS AND EXPLANATIONS WITHIN THE ABOVE CONSENT TO THE OPERATION PROPOSED, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETEION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE THAT I READ AND WRITE ENGLISH.

Patient, Parent or Guardian	Date
Witness	Date
Doctor	Date