CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY

Patient Name_________________________
Date________________________________

Patient, please initial each paragraph after reading.

1. I hereby authorize ____________________, and any other agents or employees of **Dyer Family Dentistry**, and such assistants as may be selected by them, to treat the conditions described below: ____
2. The procedure(s) necessary to treat the condition(s) have been explained to me by _____________ And I understand the proposed procedure to be: ____.
3. I have been informed that this is an elective procedure and that possible alternative methods of treatment (if any) or no treatment at all are choices that I have.
4. It has been explained to me that there are certain inherent and potential risks in any treatment procedure. The more common operative risks include, but are not limited to; pain, infection, swelling, bleeding, bruising, discoloration, and temporary or permanent numbness and tingling of the lip, tongue, gums, chin, cheek, or teeth. There can also be pain, numbness or inflammation from injection into a vein. There is a possibility of injury to, or stiffness of, the facial muscles and changes in the occlusion or the jaw joint. Stretching of the corners of the mouth may occur with resultant cracking and bruising. There is also the possibility of injury to adjacent teeth, fillings in other teeth, other tissues, referred pain to the ear, neck, or head, nausea vomiting, allergic reaction, bone fracture, and delayed healing. Sinus complications that may occur are, bleeding, infections, reaction to drugs or to anesthetic, including heart failure, or the need to repeat all, or part, of the surgery.
5. It has been explained to me that, during the course of the procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in paragraph 2. I therefore authorize and request that the persons described in paragraph 1 perform such procedures, as are necessary and desirable in the exercises of professional judgment. The authority granted in this paragraph 5 shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.
6. I consent to the administration of anesthesia, including local anesthesia, and Nitrous Oxide sedation, with the exception of: ____
(Name of particular anesthetic) to which I said I was allergic.
7. Medications, drugs, anesthetics, and prescriptions all have the potential to cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol and other drugs.

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

SIGNATURES

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON (AGE 19 OR OLDER)　　　DATE

____　　　__________________

WITNESS (professional staff member)　　　DATE