Center for Oral and Facial Surgery
Associates in Oral & Maxillofacial Surgery, P.C.

CONSENT FOR TEMPOROMANDIBULAR JAW JOINT SURGERY or ARTHROCENTESIS PROCEDURE AND ANESTHESIA FOR EITHER

You have the right to be informed about your condition and the recommended treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to provide information so that you may give or withhold your consent.

Patient Name:______________________________ Account #:______________

I hereby authorize Dr.______________________________and staff to perform the following

procedure:______________________________and to administer the

anesthesia I have chosen, which is:

☐ local anesthesia ☐ nitrous oxide/oxygen analgesia ☐ intravenous sedation ☐ general anesthesia

1. I have been informed of possible alternate methods of treatment (if any) including ______________

   ______________________________.

   I understand that these other forms of treatment, or no treatment at all, are choices that I have and the risks of those choices have been presented to me.

2. I understand that my jaw joint condition may be due to several causes including traumatic injury, disc displacement, developmental defect, arthritis, infection, or damaging habits. I realize that some of these conditions may continue in spite of the successful completion of the surgery.

3. The surgery or procedure as I understand it is: ______________________________.

4. I understand that there may be alternative treatments including no treatment at all, and I wish to proceed with the recommended procedure.

5. The proposed surgery or procedure has been described and rare possible complications and side effects have been discussed, including, but not limited to:
   A. Objectionable scarring of the incision line, possibly requiring revision.
   B. Post-operative swelling bruising, hematoma (blood clot) formation and discomfort.
   C. Wound infection
   D. Reaction-and rejection of implant materials·
   E. Malocclusion (change in bite) after surgery
   F. Facial nerve injury causing loss of control of muscles of the face particularly of the eyelid and forehead.
   G. Ear problems including infection, hearing loss, ringing in the ears or equilibrium problems.

6. I understand that additional treatment may be necessary, including physical therapy, behavior modification, splint therapy, reconstruction dentistry, orthodontics or further joint surgery.

7. I understand that there can be no guarantee of resolution of my present symptoms or jaw dysfunction. In rare instances there are increased symptoms.

8. During surgery some unforeseen condition may be discovered that might cause a change in surgery from that explained above. I authorize my doctor to perform such procedures as are necessary and advisable in the exercise of his professional judgment.

9. **<u>ANESTHESIC RISKS</u>** include: allergic reactions (previously unknown) to any of the medication used, discomfort, swelling or bruising at the site where the drugs are placed into a vein. Nausea and vomiting, although not common, are unfortunate side effects of intravenous anesthesia. Intravenous sedation is a serious medical procedure and carries with it the risk of brain damage, stroke, heart attack or death.

10. **<u>YOUR OBLIGATIONS IF IV ANESTHESIA IS USED:</u>**
    A. 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, which may be up to 24 hours.
    B. During recovery time {24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
    C. You must have a completely empty stomach. **<u>IT IS VITAL THAT YOU</u> HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING.**
    D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, using only a **small sip of water**.

11. I have truthfully disclosed my past medical history including all diseases and medications, and alcohol and drug use. I understand that the use of certain drugs can cause life-threatening complications, and it is important to reveal the use of such drugs before surgery and anesthesia.

12. I agree to comply with the recommendations made by my doctor, realizing that lack of cooperation may result in a less-than-optimal result.

13. I certify that I have had an opportunity to read and fully understand this document and that all blanks were filled in prior to my signing this form. All my questions have been answered to my satisfaction, and I am willing to undergo the proposed surgery. I also state that I speak, read and write English.

____

Patient or Legal Guardian Signature Date

____

Witness Signature Date

____

Doctor Signature Date

If surgery date is different than date above, I have had the opportunity to again review, discuss, and change this informed consent.

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Patient's (or Legal Guardian's) Signature Date