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

CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY & ANESTHESIA

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 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. My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment (most complications are extremely rare) and in this specific instance they include, but are not limited to:
   A. Post-operative discomfort and swelling that may require several days of at-home recovery.
   B. Prolonged or heavy bleeding that may require additional treatment.
   C. Injury or damage to adjacent teeth or fillings.
   D. Post-operative infection that may require additional treatment.
   E. Stretching of the corners of the mouth that may cause cracking or bruising, and may heal slowly.
   F. 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.
   G. A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
   H. Fracture of the jaw (usually only in more complicated extractions or surgery).
   I. Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums, or tongue and which may persist for several weeks, months or, in rare instances, permanently.
   J. Opening of the sinus (a normal air chamber situated above the upper teeth) requiring additional surgery or treatment.
   K. Dry sockets (loss of blood clot from extraction site and resulting inflammation of the bone).
   L. Allergic reactions (previously unknown) to any medications used in treatment.

3. It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph 2 above. I authorize my doctor and staff to use professional judgement to perform such additional procedures that are necessary and desirable to complete my surgery.

Initial: _____

4. **ANESTHETICS 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 anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, does carry with it the rare risks of heart irregularities, heart attack, stroke, brain damage, and even death.

5. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**
   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. This 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. **IT IS VITAL THAT YOU 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**.

6. It has been explained to me, and I fully understand, that a perfect result is not or cannot be guaranteed and I give my free and voluntary consent for treatment. I realize that my doctor may discover conditions requiring different surgery from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgement.

PLEASE ASK YOUR DOCTOR IF YOU HAVE QUESTIONS CONCERNING THIS CONSENT FORM.

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read and write English.

_____

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

_____

Witness' Signature Date

_____

Doctor's Signature Date

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

_____

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