ORAL SURGERY & EXTRACTIONS

Patient Name: ____
Date: ____

I hereby authorize Dr. ___________________________ and his/her dental care team to perform the following procedure: ____as a result of the diagnosis of ____.

Dr. _______________________ has explained to me the proposed treatment and the anticipated results of that treatment. I understand this is an elective procedure and there are other forms of treatment available, including the option of no treatment. The consequences of not treating this condition include but are not limited to: infection, swelling, pain, periodontal disease, malocclusion, fracture of the jaw and/or loss of bone. Impacted wisdom teeth are subject to and responsible for infections, cysts and tumors, cavities, pressure damage and periodontal damage to normal teeth and gums and bone.

Dr. _____________________ has explained to me there are certain risks in this treatment plan or the procedure he/she will be performing. These risks include but are not limited to:

- Injury to a nerve resulting in numbness, burning or tingling of the chin, lip, cheek, gum on the side on this the procedure in being performed as well as loss of taste in the case of the tongue. These nerve injuries can last for several weeks, months or in rare instances, be permanent.
- Drug and medication reactions, although rare, may occur. These reactions could include redness, swelling, pain, itching, vomiting and/or anaphylactic shock
- Postoperative infection accompanied by malaise or fever which may require immediate additional treatment
- Sinus involvement which would require additional surgery
- Muscle or jaw restriction of the mouth opening for several days or weeks as well as possible temporomandibular joint (TMJ) pain or dislocation
- Injury to adjacent teeth may occur which will require further dental care
- In rare circumstances breakage of the jaw, cardiac arrest or mortality
- Postoperatively discomfort, swelling, discoloration and bleeding may occur that may necessitate several days of recuperation at home
- A small piece of root tip left in the jaw would require extensive surgery
- Stretching of the corners of the mouth which may cause cracking and bruising
- Other ____

Unforeseen conditions may arise during the procedure that may require a different procedure than noted above. Therefore, I authorize Dr. ___________________ to perform such procedures when in his/her professional judgment, they are deemed necessary.

I understand it is my responsibility to contact the dental care team and seek immediate medical attention should any unusual circumstances present themselves postoperatively.

SAMPLE

I voluntarily assume any and all probable risks, including but not limited to those situations addressed above which may be associated with any phase of the oral surgery care treatment plan. I shall diligently follow any preoperative instructions given to me. I understand the dental care team cannot make any promises or guarantees of the outcome or result.

By signing below, I am acknowledging I have read or had this document read to me in its entirety, have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it is presented. I understand the potential risks, complications and side effects. I have elected to proceed with the dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

Patient (or Legal Guardian) Signature:
Patient Printed Name:
Date:

Doctor's Signature: ____
Date: ____

SAMPLE