

INFORMATION AND CONSENT FOR ORAL SURGERY

Salem Dental Studio
Steven N. Lind DMD PC
(503) 566-7000
Fax: (503) 363-8886

1. I authorize _____ to treat the condition(s) described below.

2. I understand that this is an elective procedure, and that other forms of treatment or no treatment at all are choices that I have. I have been informed of possible alternative methods of treatment, and elect to proceed with above described procedure(s).
3. I understand 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, the following:
 - A. Post-operative discomfort and swelling that may necessitate several days of home recuperation.
 - B. Bleeding that may be prolonged.
 - C. Post-operative infection, requiring additional treatment, including antibiotic therapy and/or surgery.
 - D. Restricted mouth opening for several days, weeks or longer; injury to the jaw joint (TMJ), which in remote instances, may be permanent and/or require additional treatment.
 - E. Injury to teeth, fillings, and other soft tissues of the mouth, including gums, cheek, palate, lips, throat and tongue.
 - F. Stretching of the corners of the mouth with resultant cracking and bruising.
 - G. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery, or jeopardize other anatomical structures, such as sinuses nerves blood vessels, or teeth.
 - H. Jawbone fracture.
 - I. Injury to the nerves underlying the teeth, and the nerve which goes to the tongue, resulting in numbness, tingling, pain or abnormal sensation of the chin, lip, cheek, gums and/or tongue, including loss of taste, on the operated side. This may persist for several weeks, months, or in remote instances, permanently.
 - J. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery
 - K. Cardiac arrest, heart irregularities or respiratory problems
 - L. Other: _____
4. I understand that during the course of the procedure(s), unforeseen conditions may be revealed that necessitate a change in treatment plan, or additional treatment, in which case the dentist will explain to me the change and the reason for it. I authorize the dentist to perform treatment, which was not originally planned if the dentist deems it is necessary in the exercise of professional judgment.
5. I understand that NOT treating this condition could cause problems including but not limited to: cyst or tumor formation; destruction of jawbone and associated structures; injury to the teeth; earaches, headaches, and facial pain; jaw joint problems; sinus, jaw, or facial infection; nerve injury.
6. Medications may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile or hazardous devices or work, while taking such medications and/or drugs; or until fully recovered from the effects of same. 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 and have a responsible adult with me until I have recovered from the effect of the medication given to me.
7. It has been explained to me, and I understand that a perfect result is not guaranteed or warranted

and cannot be guaranteed or warranted.

8. I understand that Dr. is not in this office everyday, and that he/she may not be here for any necessary postoperative appointment. I consent to have post-operative care renders by dentists other than Dr. _____.

I certify that I have read and fully understand this consent/or surgery, or that it was translated to me, and that all blanks or statements requiring insertion or completion were dilled in, and that "NA" was written beside all statements, which were not applicable to my treatment before I signed.

PLEASE ASK THE DENTIST IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

Comments:

Patient Signature
(Parent/Guardian if under 18)

Date

Doctor Signature

Date

Witness Signature

Date

Witness Name (Printed)