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CONSENT FOR TREATMENT AND ANESTHESIA

The extraction of teeth and other oral surgical procedures in most instances are routine and usually not associated with post-operative complications. Some remote possibilities include:

1. Post-operative bleeding .
2. Injury to adjacent teeth and/ or filling.
3. Post-operative infection requiring farther treatment.
4. Fracture of the jaw.
5. Altered sensation of lip and/or tongue on side of surgery; usually resolved over a period of time (weeks or months) rarely permanent, but possible.
6. Necessity-to allow small root fragments to remain within the jaw when their removal would require further extensive surgery.
7. Sinus involvement associated with extraction of upper teeth including opening between sinus and area of surgery or tooth fragment displaced into sinus.
8. Discoloration (black and blue) or bruising.of face and jaws.
9. Reaction to antibiotics or anesthetic.

The following are post-operative conditions (not complications) commonly associated with surgery:

1. Difficulty opening mouth.
2. Pain.
3. Swelling.

The purpose and nature of the surgical treatment has been explalned to me. I also understand the risks that arelnvolved ln the performance of such treatment. I understand the nature of the proposed anesthesia and realize that in most cases, general anesthesia or sedation is associated with more risk than with local anesthesia. I hereby give consent to the proposed surgery/anesthesia deemed necessary.

SIGNATURE: _____ Date: _____
Patient or Guardian

WITNESS:_____

DOCTOR: _____