Informed Consent for Oral Surgery

It is our responsibility to advise you of possible reactions to treatment so that you may make informed decisions about your care. Please be advised that the vast majority of our patients do quite well after oral surgery and heal normally.

I understand that the following dental care has been recommended by my dentist:

- ☐ Extraction of teeth, root tips, wisdom teeth: #'s _____
- ☐ Surgery of the gum, jaw bone or other oral structures_____
- ☐ Implant placement. _____
- ☐ Bone or soft tissue grafts _____
- ☐ Other_____

Reasons for recommended care include but are not limited to:

- ☐ Infection that may spread and/or cause pain, swelling or other symptoms.
- ☐ Condition may worsen, cost more and/or require additional treatment if delayed.
- ☐ Replace missing teeth that can result in such problems as bite collapse, shifting teeth, root cavities and/or gum problems.
- ☐ Other_____

_____

I understand that dental procedures entail risks which may include but are not limited to:

1. Post-operative infection, bleeding, bruising, swelling, pain and/or sensitivity that may require additional treatment.

2. Injury to sinuses that may require surgical repair or additional treatment.
3. Injury to nerves resulting in temporary and/or permanent numbness, pain and/or tingling of the tongue, lip, chin or other areas.
4. Damage or breakage of other teeth, fillings, crowns or dental work.
5. Reactions and/or side effects to local anesthetics, sedatives, or other medications.
6. Delayed healing of extraction sites called dry sockets requiring additional care.
7. Failure of the dental procedure, necessitating additional treatment.
8. Breakage of roots that may be left in place.
9. Complications during treatment that may require referral to a specialist.
10. Other_____

I understand my condition, recommended treatment(s) and the risks of this care. I also understand the risks of not undergoing treatment. I have not been offered any guarantees and all my questions have been answered.

Office and/or Doctor's Name _____

Patient Signature _____ Date _____

Witness_____ Date _____