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Informed Consent for Oral and Maxillofacial Surgery

Patient's Name: ____

Procedure: Surgical removal of tooth/teeth number(s): ______________________________

Location Description: ____

Alternatives to Procedure: Risks to my health if the above procedure is not performed are included, but not limited to:

- Infection;
- Cyst or tumor formation;
- Periodontal (gum) disease; and
- Increased risk for complications if removal is required at a later time.

Possible Complications which have been discussed with me, include but are not limited to:

- Injury to the nerves, lips and/or tongue causing numbness which could be permanent;
- Bleeding and/or bruising which may be prolonged;
- Dry socket;
- Involvement of the sinus above the upper teeth;
- Infection;
- Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and increased risk of complications;
- Injury to adjacent teeth or fillings.

<u>To be read and signed by Responsible Party:</u>

I, __________________________________, understand that during treatment, complications may arise which make treatment more difficult or may require additional dental surgery. If any unforeseen conditions arise during the procedure, I request and authorize the doctor to do whatever he deems advisable to correct the condition.

I agree to cooperate completely with Dr. Whitman and will follow post-operative instructions to the best of my ability for my own comfort and safety. In understand that no guarantee of success has been or can be given. I have had the opportunity to ask questions concerning these procedures.

Signature: __________________________________ Date: ____________________

Relationship to Patient: ________________________

Doctor's Signature: ___________________________

Witness Signature: ____________________________