

INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA (I.V., NITROUS OR LOCAL)

*This consent form is to educate and inform you regarding your surgery.
It does not take away your legal rights.*

INITIAL ALL LINES

_____ I consent for Dr. _____, with the aid of his staff to perform the stated surgery: _____

_____ I have been informed of alternatives, if any, to the stated surgery or treatment.

_____ I understand the complications and natural side effects to surgery listed below are possible:

1. Injury to the nerve underlying the teeth resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue on the operated side; this may persist for several weeks, months or in remote instances, permanently from surgery or injection of local anesthesia.
2. Postoperative pain and swelling that may necessitate several days of home recuperation.
3. Injury to adjacent teeth, fillings, crowns, and bridges.
4. Postoperative infection requiring additional treatment or surgery.
5. Stretching of the corners of the mouth resulting in cracking, bruising, or abrasions.
6. Restricted mouth opening for several days or weeks.
7. Decision to leave a small piece of root in your jaw when its removal would require extensive surgery or possible nerve injury.
8. Heavy bleeding that may be prolonged.
9. Breakage of the jaw requiring wiring of the teeth together for 4-6 weeks.
10. Opening of the sinus (a normal cavity above the upper teeth) requiring additional surgery.
11. If intravenous (I.V.) medication is used, soreness, infection, and discoloration may develop at the injection site or along the vein.
12. "Dry Socket" may become present 3-5 days after surgery that may require additional office visits and treatment.

_____ I consent to the administration of such local, intravenous (I.V.), and/or general anesthesia as agreed to by Dr. _____, and myself.

_____ Medication drugs, anesthetics, and prescriptions may cause drowsiness or lack of awareness and coordination. These effects can be increased by the use of alcohol or other drugs. I have been advised not to drive or operate dangerous equipment while taking such medications until fully recovered.

_____ I agree and understand that I am not to have had anything to eat or drink for 8 hours before my surgery appointment.

_____ (Female) I understand that antibiotics, pain pills, and anesthesia drugs may alter the effectiveness of my birth control pills. For the duration of my current cycle, I should use an additional method of birth control.

_____ The fee for services have been explained to me. I understand that I am financially responsible for this fee regardless of any insurance coverage. I agree to pay my bill today. I also agree to pay all expenses incurred in the collection of my bill.

_____ I viewed the video on wisdom teeth removal.

Patients signature (18 and over) Date

Parent or Legal Guardian Date

Witness- relationship to patient Date

Assistant Date

Harrison D. Fortney, D.D.S Date

Albert W. Lin, D.D.S

Robert T. Gramins, D.D.S.