ORAL & FACIAL SURGERY FOR ADULTS AND CHILDREN

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INFORMED CONSENT FOR TREATMENT, SURGERY, AND ANESTHESIA

This is my consent for the doctors of Oral & Facial Surgery for Adults and Children to perform treatment, surgery, and/or anesthesia as explained to me.

I understand that the purpose of the treatment/surgery is to treat and possibly correct my diseased oral and facial tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present condition will probably worsen in time. I have been informed of possible alternative methods of treatment, if any.

My doctor has explained to me that there are certain inherent and potential risks in any treatment or procedure and that in this specific instance, such operative risks may include, but are not limited to:

1. Post-operative discomfort and swelling that may necessitate several days of home recuperation.
2. Heavy bleeding that may be prolonged.
3. Injury to adjacent teeth and fillings.
4. Post-operative infection requiring additional treatment.
5. Stretching of the corners of the mouth with resultant cracking and bruising.
6. Restricted mouth opening for several days or weeks.
7. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
8. Breakage of the jaw.
9. Injury to the nerves, underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, or tongue on the operated side, which may persist for several weeks, months or in rare instances, permanently.
10. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

I agree and understand that if I plan to have sedation or general anesthesia (be put to sleep) I am not to have any food or liquids for 6 hours prior to surgery. I understand that I may have tea, clear soda (like Sprite), water or apple juice up to 2 hours prior to surgery.
I consent to the administration of such anesthesia as we discussed prior to the procedure.

I am aware that medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness. I have been advised not to operate any vehicle, hazardous devices or work while taking such medications/drugs, until fully recovered from their effects. I agree not to operate any vehicle or hazardous device for at least 24 hours following administration of any anesthetic or sedative medications other than local anesthesia. I agree to have an escort drive me home if I have received sedative medications.
I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires a general anesthetic.

If any unforeseen condition should arise in the course of the operation requiring the doctors' judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he may deem advisable.
No guarantee or assurance has been given to me that the proposed treatment will be curative or successful to my complete satisfaction.

Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment or worsening of my present condition despite the care provided. It is, however, the doctors' opinion that therapy would be helpful and a worsening of my condition would occur sooner without the recommended treatment.

I have had an opportunity to discuss my past medical history, including any serious problems/injuries, with my doctor.
I agree to cooperate completely with the recommendations of my doctor while I am under his care, realizing that any lack of, it could result in a less than optimum result.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT. I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY COMPLETE SATISFACTION. I ALSO STATE THAT I READ AND WRITE ENGLISH.

Witness: Signature of Patient or Legal Guardian: Date:

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Doctor:

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