MARATHON DENTAL HEALTH

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CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY

You have the right to be informed about your condition and the recommended treatment plan, so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but rather an effort to provide information so that you may give or withhold your consent.

_____ _____
Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor before initialing.

_____ 1. My condition has been explained to me as: _____

_____

_____2. The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the treatment to be:_____

_____

_____3. I have been informed of other alternative methods of treatment (if any).

_____4. My doctor has explained to me that there are certain inherent and potential risks and side
effects associated with my proposed treatment and in this specific instance they include, but are not limited to:

_ Post- operative discomfort and swelling that may require several days of at home recovery.
_ Prolonged or heavy bleeding that may require additional treatment.
_ Injury or damage to adjacent teeth, crowns, or fillings.
_ Post- operative infection that may require additional treatment.
_ Stretching of the corners of the mouth that may cause cracking or bruising and may heal slowly.
_ Restricted opening of the mouth during healing. Sometimes related to swelling and and muscle soreness and sometimes related to stress on the jaw joints (TMJ), . especially when TMJ problems already exist
_ A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
_ Fracture of jaw (with complicated extractions or surgery).

(continued on back)

_ Injury to the nerve underlying lower teeth resulting gin pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums or tongue.
_ Opening of the sinus (a normal chamber situated above the upper teeth, requiring additional surgery or treatment.)
_ Dry socket (loss of blood clot from extraction site).
_ Allergic reactions (previously unknown) to any medication used in treatment.

_____ 5. It has been explained that during the course of the treatment unforeseen conditions, may be revealed that may require changes in procedure noted in the paragraph #2. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

_____6. The anesthetic I have chosen for my surgery is:

☐ Local Anesthesis
☐ Local Anesthesia with Nitrous Oxide/Oxygen
☐ Local Anesthesia with Intravenous Sedation

_____7. Anesthetic Risks Include:

- Discomfort, swelling, bruising, infection, prolonged numbness or allergic reactions.

_____8. It has been explained to me, and I fully understand, that a perfect result is not or cannot be guaranteed.

Please ask your doctor if you have any questions concerning this consent form.

Signature:_____ Date:_____

Witness:_____

Doctor:_____

Blood Pressure:

1. _____
2. _____
3. _____