Darius Smith D.D.S., PC

IV Sedation, Extractions, Implants
Periodontal surgery, Root Canals and Consulting

AUTHORIZATION AND CONSENT FOR ORAL SURGERY

Patient name (Print): _____ Date: _____

The following procedure(s) has/have been recommended: _____

_____

Extraction of teeth, as well as other surgical procedures are irreversible. Whether routine or difficult, such extractions are considered surgical procedures. As in any surgical procedure, I understand that there are risks associated with the proposed treatment including but not limited to:

(Initial areas listed)

_____ 1. Swelling and/or bruising and discomfort in the surgical area.
_____ 2. Stretching of the corners of the mouth resulting in cracking and bruising.
_____ 4. Dry socket pain beginning a few days after surgery, usually requiring additional care.
_____ 5. Numbness or altered sensation in the teeth lip and chin due to the closeness of a tooth roots to the nerves, which can be bruised or injured.
_____ 6. Sensation most often returns to normal common but in rare cases, the lost maybe permanent.
_____ 7. Trismus – limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes is the result of jaw joint discomfort (TMJ), especially when TMJ disease and symptoms already exist.
_____ 8. Bleeding – Significant bleeding is not common, persistent oozing can be expected for several hours after completion of surgery.
_____ 9. Sharp ridge or bones splinters may form later at the edges of the socket. These may require another surgery to smooth or remove them.
_____ 10. Incomplete removal of a tooth fragment – to avoid injury to vital structures such as nerves or sinus, sometimes-small root tips may be left in place. Sinus involvement: the roots of the upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus, or in opening may occur in the mouth which could require additional care.
_____ 11. Jaw fracture – while quite rare, it is possible and difficult or deeply impacted teeth.

Most procedures are routine and serious complications are not expected. However, those that do occur most often minor and can be treated successfully.

I have not been given any guarantee or warranty of success for this treatment, and understand that each patient is different, making it impossible to predict results exactly. Although improvement is expected, I also understand that my condition may be the same better or worse after treatment in that ongoing care maybe necessary. I understand that to aid in successful treatment and to lessen the dangers of complications, I must meet certain requirements, namely excellent oral hygiene, proper diet with restrictions on certain the hard or chewy foods, strict adherence to instructions about using medications, wearing of appliances, if applicable, and cooperation and keeping appointments. I have provided a complete and accurate statement of my medical history. I have had the opportunity to ask questions about the information on this form and have been given answers that are satisfactory to me.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND FURTHER CERTIFY THAT THE DOCTOR HAS EXPLAINED THE RISK ASSOCIATED WITH THE PROCEDURE TO ME. MY SIGNATURE BELOW SIGNIFIES MY ACKNOWLEDGEMENT THAT I BELIEVE I HAVE RECEIVED SUFFICIENT INFORMATION TO PROCEED WITH THE RECOMMENDED TREATMENT. ALL BLANKS WERE FILLED IN PRIOR TO MY SIGNING. I HEREBY AUTHORIZE CONSENT TO HAVE THIS ORAL SURGERY TREATMENT.

_____

Patient/Parent or Legal Guardian Signature Date

_____

Doctor's Signature Date

_____

Witness Signature Date