PATIENT CONSENT FOR SURGERY, PERIODONTAL THERAPY, AND ANESTHESIA

DIAGNOSIS I understand that I have:

PROCEDURES I hereby authorize Dr. Everett to perform any or all of the following procedures:

ALTERNATIVES I understand that alternative plans of treatment might be employed, and the merits and benefits have been discussed with me.

Although problems and complications are uncommon and unpredictable, they can happen during or after surgery/periodontal therapy. We will do all that we can to minimize the risks, but the following are a few of the more common problems that can occur in any procedure, despite our best efforts:

INFECTION In rare cases, an infection may require hospitalization and can be a life-threatening situation. It is possible to develop an infection even when you are taking antibiotics.

SWELLING Certain procedures may result in oral/facial swelling. Dr. Everett will discuss how extensive he anticipates your swelling will be prior to your procedure.

BLEEDING Slow oozing of blood is normal for 12-24 hours after your procedure. Some situations, such as taking aspirin, can result in longer periods of bleeding. If your bleeding is heavy or persists for a long time, contact Dr. Everett immediately because you may require additional treatment to stop the bleeding.

PAIN All procedures typically result in some type of discomfort. Dr. Everett will discuss how the post-surgical discomfort will be managed prior to your procedure.

NERVE DAMAGE Some teeth are located next to nerves that give feeling to your lips, gums, and other teeth. One or more nerves may get damaged during your treatment, giving an area numbness that does not go away for a long time. In rare cases it may be permanent. Dr. Everett will do everything he can to minimize this risk.

SINUS OPENING Upper back teeth are next to the floor of the sinus cavities on each side, which connects with the nose. Occasionally, an extraction can create a small communication between the sinus and the mouth. If this communication doesn't heal, another procedure will be needed to close the opening.

NEARBY TOOTH DAMAGE Occasionally during certain procedures, adjacent teeth may be damaged. **This damage may include, but is not limited to, loosening of teeth, lost fillings, loosening of crowns, etc.** We'll do everything we can to avoid this, but if it occurs, you may need to have additional dental treatment at your own expense.

OTHER PROBLEMS There are other potential problems that can occur during and after your procedure. **These may include, but are not limited to sensitivity to hot or cold, restricted mouth opening, joint pain, bruising, phonetic (speech) interference, gum recession, food impaction between teeth, dry socket, vertigo, etc.**

DRUG/ANESTHESIA REACTIONS You can unexpectedly react to any drug, ranging from a rash to having a life-threatening crisis. If you know of any past allergies, are taking any drugs you have not told Dr. Everett about, or have any major illness you failed to report, it is imperative you tell us now, or you may be risking your own health.

UNFORSEEN CONDITIONS I fully understand that during and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant, in the judgment of Dr. Everett, additional or alternative treatment pertinent to the success of comprehensive treatment. I approve any modification in design, materials, or care, if Dr. Everett feels this is in my best interest.

NO WARRANTY I understand that if the proposed treatments are successful, the results should include increased long-term retention of teeth, lowering of disease activity, and decreased disease progression. I am aware that periodontitis is a chronic and incurable disease and no guarantee or treatment warranty is expressed or implied. I understand that risk of failure exists, with the relapse and worsening of my present condition always a possibility despite the best of care. I understand that my responsibility in the success of my treatment is vital, and that I must continuously employ the best home care as well as continue with a program of professional maintenance suggested by Dr. Everett. I also understand that continued and periodic examination and care by my general dentist is vital to my dental health.

PHOTOGRAPHS I consent to photography, filming, recording, and x-rays of my mouth (oral cavity) and facial structures, as well as their publication, and for use for educational and scientific purposes, provided my identity is not revealed.

I certify that I have read and fully understand the above authorization and informed consent to treatment and the explanations referred to above.

SIGNATURE: DATE:

PRINTED NAME: DATE:

WITNESS: DATE: