CONSENT FOR ORAL SURGERY AND ANESTHESIA

Patient: _____

Sx Date/Time: _____

1. This is my consent for Dr. Everett to perform the following treatment/ procedure/ surgery:_____

_____as previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned surgical procedure.

2. I understand that the purpose of the procedure/ surgery is to treat and possibly correct my diseased oral/ maxillofacial tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen with time, and the risks to my health may include, but are not limited to, the following: swelling; pain; infection; cyst formation; periodontal (gum) disease; dental caries; malocclusion; pathologic fracture of the jaw; premature loss of the teeth; and/ or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

3. Dr. Everett has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to:

_____A. Postoperative discomfort and swelling that may necessitate several days of home recuperation.

_____B. Heavy bleeding that may be prolonged.

_____C. Injury to adjacent teeth and fillings and/or crowns.

_____D. Postoperative infection requiring additional treatment.

_____E. Stretching of the corners of the mouth with resultant cracking and/or bruising.

_____F. Restrictive mouth opening for several days or weeks.

_____G. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.

_____H. Fracture of the jaw.

_____I. **Injury to the nerve underlying the teeth resulting in numbness or tingling of the lips, chin, gums, cheek, teeth and/or tongue on the operated side, or loss of taste sensation: these may persist for several weeks, months, or in rare instances may be permanent**.

_____J. Opening of the sinus cavity (a cavity situated above the upper teeth) requiring additional surgery.

4. **I agree and understand that I am not to have and/or had anything to eat or drink for <u>Six</u> hours before my surgery.**

5. I understand that, if I desire or if Dr. Everett advises, sedative drugs may be used to reduce my anxiety and discomfort by making me relaxed and sleepy. Be advised that this type of sedation, conscious sedation, **<u>is not</u>** general anesthesia. You will be sedated but conscious and may be aware of your surroundings. These drugs may also reduce my ability to remember events occurring on the day of the operation. I understand and agree that if sedative drugs are required before or during surgery, I **will not drive** myself home following surgery, but will arrange to be driven and accompanied home. I agree not to operate a motor vehicle or hazardous machinery for at least 24 hours following surgery. The side effect of any intravenous infusion may include nausea and vomiting and seen most frequently is phlebitis. This side effect occurs in 1 to 4 percent of patients. Phlebitis is a raised, tender, hard inflammatory response, which can have onset from 24 hours up to two weeks after the procedure. The inflammation usually resolves with local application of warm, moist heat, yet tenderness and a hard lump may be present for up to a year. Oral and Intravenous anesthesia is a serious medical procedure and although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

6. If any unforeseen condition should arise in the course of the surgery, calling for the doctor's 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.

7. No guarantee or assurance has been given to me that the proposed treatment will be curative and/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. However, it is the Doctor's opinion that therapy would be helpful, and that worsening of my condition would occur sooner without the recommended treatment.

8. I have had an opportunity to discuss with Dr. Everett my past medical and health histories including any serious problems and/or injuries.

9. I agree to cooperate completely with the recommendations of Dr. Everett while I am under his care, realizing that

9. I agree to cooperate completely with the recommendations of Dr. Everett while I am under his care, realizing that any lack of the same could result in a less than optimal result. I have been informed that an infection could cause an ensuing rejection of any materials used in my procedure.

I certify that I have had an opportunity to read and fully understand the terms and words within the above consent to the surgical procedure and the explanation referred to or made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed. I also state that I read and write English.

SIGNATURE: DATE:

PRINTED NAME: DATE:

WITNESS: DATE: