Montgomery Village Dental Center
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Consent for Oral and Maxillofacial Surgery

Patient:_____Date:_____
Doctor:_____

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR **BEFORE** INITIALING.

You have the right to be informed about your conditions and the recommended treatment plan to be used so that you may make an informed 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 is rather an effort to properly inform you so that you may give or withhold your consent.

I_____, give my consent for Dr._____and/or any associate working with Dr._____to perform the following treatment/procedure surgery:_____as previously and herein explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned treatment/procedure/surgery.

WIDSOM TOOTH EXTRACTION

___1. I hereby authorize Dr.Arefi/Nasehi and any other agents, assistants or employees selected by him to treat the conditions described as:_____
___ 2.I have been informed of possible alternative methods of treatment (if any) including:
_____
I understand the other forms of treatment or no treatment choices that I have and the risks of those choices have been presented to me.
___3. My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedures and in this specific instance such risks include, but are not limited to the following:
___A. Postoperative discomfort and swelling that may require several days of at home recuperation.
___B. Prolonged or heavy bleeding that may require additional treatment.
___C. Injury or damage to adjacent teeth or fillings.
___D. Postoperative infection that may require additional treatment.
___E. Stretching of the corners of the mouth that may cause cracking, and bruising and may heal slowly.
___F. Restricted mouth opening for several days; sometimes related to swelling and muscle soreness and sometimes related to stress on the joints of the jaw (TMJ).
___G. The decision to leave a small piece of root in the jaw when its removed would require extensive surgery or risk other complications.
___H. Fracture of the jaw(in more complicated extractions) and change in occlusion.
___I. Injury to the nerves resulting in numbness or tingling of the chin, lip, or in rare instances, permantently.
___J. Opening into the sinus or nasal cavity(a normal cavity situated above the upper teeth) required additional surgery.
___K. Referred pain to the ear, neck, or head.
___4. It has been explained to me that during the course of the procedure(s) unforeseen conditions may be revealed which will necessitate extension of the original procedure(s) or different procedure(s) from those set forth in paragraph 2 above. I authorize my doctor and his staff to perform such procedure(s) as are necessary and desirable in the exercise of professional judgement.
___5. I consent to the administration of Local Anesthesia Nitrous Oxide Analgesia/IV sedation/General anesthesia in connection with the procedure(s) referred to above.
___6. I have been made aware that certain medications, drugs, anesthetics and prescriptions

which I may be given can cause drowsiness, uncoordination and lack of awareness which also may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or hazardous machinery, and not to work while taking such medications or until fully recovered from the effects of the same. I understand that if I am to be given sedative medication during my surgery, I agree not to drive myself home and will have a responsible adult drive me home and accompany me until I am fully recovered from the effects of the sedation.

___7. Due to the potential for nausea and vomitting under anesthesia, I understand that I am not to eat or drink, anything (or have not had anything) by mouth for at least 6 to 8 hours before my surgery. **To do otherwise may be life threatening!**

___8. It has been explained to me, and I fully understand, that a perfect result is not, and cannot be guaranteed or warranted.

___9. I certify that I speak, read, and write English and have read and fully understand this consent for surgery; and that all blanks were filled in prior to my initial and signature.

PLEASE ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

_____

Patients (or leagal guardian) signature Date

_____

Witness's signature Date

_____

Doctors signature Date