CRAIGWEIL DENTAL PRACTICE

Patients name: Date:

ORAL SURGERY INFORMED CONSENT

I have been **educated and informed** regarding the following oral surgery procedure(s):
( ) procedure name(s) for which I am giving my consent and I understand the risks that are involved in performing this procedure. Specifically, I have been informed that:

1. There is a risk of **temporary** or **permanent paraesthesia** to my lower lip(s). This means that my lip may remain numb even after the procedure. Attempts to correct this involve special additional procedures.
2. The dentist must use some force to remove my tooth and this force sometimes results in **jaw fracture** that requires additional treatment and costs.
3. Postoperative **bleeding** is a normal consequence of this procedure, however, there are occasional
Instances that a patient's blood does **not clot normally**. In this case, additional care by the dentist or a physician may be necessary.
4. Some **swelling** may occur due to the trauma necessary to remove my tooth, or teeth, and this might result in **bruising.**
5. Because of the trauma to a surgical site, this site may later become **infected** and require additional care. I agree to **take the antibiotics** prescribed to me in the manner I was informed so as to minimize this possibility. (Females) Antibiotics can interfere with birth control therapy.
6. **Bone fragments** may later dislodge from the surgical site and need to be removed.
7. During procedures on maxillary teeth (upper), a tooth may sometimes dislodge into the maxillary sinus and require additional treatment and cost to be removed.
8. All the instruments and equipment used in our office are sterilized and made of stainless steel.
Occasionally, small tips of equipment break off and are left.
9. Adjacent teeth can be affected by oral surgery procedures. Adjacent teeth with decay can break. Weak crowns can pop off or break and teeth with large fillings can break. This may require additional treatment costs.
10. Later **hospitalisation** may be necessary to control complications that may result as a consequence of this procedure. If complications do occur and the dentist can not be contacted, I understand that I should go to a hospital emergency room.
11. Occasionally, a patient will have a dry socket where the tooth socket fails to heal normally. A dry
socket delays healing for several days to a week.
12. Additional potential complications described (if necessary):
13. Any further additional step may result to further cost

I have had all my questions answered regarding this procedure and its potential risks to me. I understand this consent form and the staff have answered all of my questions related to this procedure. I give permission to the dentist to do this procedure and I agree to keep my postoperative appointment in one week.

Patient (or Guardian) Signature: