Informed Consent for Dental Surgery and Anesthesia

_____ _____

Patients Name Date

Please initial in the given space

____ This is my consent for Dr. Guy McMaster and any other dentist who is working with him to perform the following treatment, procedure, or surgery.

_____
_____
_____

as explained to me previously, or other procedures necessary or advisable as necessary to complete the planned operation.

____ I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral or maxillofacial tissues. The doctor has advised me that is this condition persists without treatment or surgery, my present oral condition will probably worsen in 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 decay, malocclusion, pathological fracture of the jaw, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

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

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

_____ Heavy bleeding that may be prolonged.

_____ Injury to adjacent teeth and fillings.

_____ Stretching of the corners of the mouth with resultant cracking and bruising.

_____ Restricted mouth opening for several days or weeks.

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

_____ Breakage of the jaw.

_____ Injury to the nerve underlying the teeth resulting in loss of taste; numbness or tingling of the lip, chin, gums, cheeks, teeth, and/or tongue on the operated side that may persist for several weeks, months, or in some remote cases, permanently.

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

____I understand that I am not to have or have not had anything to eat or drink for ____ hours before surgery.

____I consent to administration of local anesthetic and intravenous sedation as deemed necessary by Dr. McMaster or his designated assistants to accomplish this procedure. Medications, drugs, anesthetics, and prescriptions may cause drowsiness, and lack of awareness or coordination, which can be increased by the use of alcohol or other drugs. Thus, I have been advised not to operate any vehicle, automobile, or hazardous devices, or work while taking such medications and/or drugs; or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four (24) hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office for my care. I agree not to drive myself home after surgery and will have a responsible adult drive m home after my discharge from Dr. McMaster's office.

____ I understand that there are certain risks with IV sedation. The include, but are not limited to complications at the site of the venipuncture, bruising, hematoma, irritation from medications, phlebitis (inflammation of the vein), or drug related complications of nausea and vomiting, allergy, respiration depression, laryngospasm, recurrence of amnesia, brain damage, coma, loss of limb, or death.

____ If any unforeseen condition should arise in the course of the operation, 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.

____ No guarantee or assurance has been given to me that proposed treatment would be curative and/or successful to my complete satisfaction. Due to individual patient difference there exists a risk of failure, relapse, selective pretreatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur without the recommended treatment.

____ I have had the opportunity to discuss with Dr. McMaster my past medical history, including any serious problems and/or injuries.

____ I agree to cooperate completely with the recommendations of Dr. McMaster while I am under his care, realizing that any lack of same could result in a less optimum result.

____ I acknowledge and understand and duly evidence in writing by executing this form I have been informed in general terms of the following:

A diagnosis of the condition requiring the procedure(s)

The nature and purpose of the procedure(s)

The material risks of the procedure(s)

The practical alternatives to such procedure(s)

The likelihood of success of the procedure(s)

The prognosis if the procedure(s) is/are rejected

Such was provided through the use of pamphlets, booklets, or other means of communication or through conversations with the responsible doctor or other health personnel under the supervision and control of the responsible doctor, other health personnel involved in the course of this treatment, nurses, doctors, assistants, hygienists, trained counselors, or patient educators.

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

_____ _____

Patient, Parent, or Guardian Printed Name Date

_____ _____ _____

Witness Signature Date

Witness Dr. Guy McMaster Date