ALL SMILES DENTISTRY
CONSENT FOR ORAL SURGERY

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 condition and the recommended treatment plan 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.

PATIENT NAME:_____DATE_____

_____1. I hereby authorize Dr. Steinhubel, and any other agents, assistants or employees selected by him, to treat the condition(s) described as:

_____

_____2. The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure(s) to be:_____

_____

_____3. I have been informed of possible alternative methods of treatment (if any), including: 1. NO TREATMENT, 2._____

_____

I understand that other forms of treatment or no treatment at all are choices that I have and the risks of those choices have been presented to me. I understand that I can opt to have this procedure performed by an Oral Surgeon and if certain complications arise during the procedure I may elect, or the doctor may opt, to end procedure and refer to an Oral Surgeon. I understand restorations are recommended to replace missing teeth.

_____4. My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure 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. **Dry socket** (inflammation of the bone), which may require placement of a medicated dressing that may relieve the pain.
_____H. **Numbness** or tingling of the lip, gums, chin and/or tongue which may last from several days to several months; or partial or total numbness which may last forever (be permanent).

_____I. The decision to leave a small **piece of root** in the jaw when its removal would require extensive surgery or risk other complications.

_____J. Fracture of the **jaw** (in more complicated extractions).

_____K. Opening into the **sinus** (a normal cavity situated above the upper teeth) requiring medications and maybe additional surgery.

_____5. 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 judgment.

_____6. I consent to the administration of **local anesthesia** in connection with the procedure(s) referred to above.

7. I have been made aware that certain medications and **prescriptions** that I may be given can cause drowsiness, lack of awareness and/or coordination that 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 medication, or until fully recovered from the effects of the same. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication.

_____8. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training. I consent to the taking of such pictures with the following conditions:

_____A. The name of the patient and his/her family is not used to identify said pictures.

_____B. Said pictures to be used only for purposes of medical/dental study, training, research.

CONSENT: I have read and understand the above paragraphs and realize that a perfect result cannot be guaranteed. All my questions have been fully answered to my satisfaction regarding this consent and I fully understand the risks involved. I also state that I speak, read, and write English.

_____

Patient's (or legal guardian's) signature Date and Time

_____

Witness' signature Date

_____

Doctor's signature Date