

Consent Form for Third Molar Surgery

The surgical procedure that is to be performed has been explained to me and I understand the nature of my condition and of the proposed treatment. I also understand what health risks exist if the procedure is not done, such as pain, infection, decay, damage to other teeth, and a more difficult surgery as I get older.

I agree to the administration of local anesthesia and other therapeutic measures as discussed that may be necessary for my comfort, safety, and well-being.

I realize that occasionally there are complications with this surgery and the medications. The more common complications include pain; swelling; bleeding; dry sockets; limited mouth opening; infection; bruising and discoloration of the skin; and temporary numbness and/or tingling of the lip, chin, gums, cheek, teeth, or tongue.

In some cases, even with the utmost care there can be referred pain to the ear or neck; stiffness of the neck and facial muscles; changes in the bite and temporomandibular joint (TMJ); nausea; allergic reactions; bone fractures; injury to adjacent teeth; delayed healing; and permanent numbness of nerves in the facial area. Sinus complications which may occur from the removal of upper teeth include a root tip or tooth in the sinus, or development of a lingering opening into the sinus from the mouth which could require sinus treatments following this surgery.

Medications given during or after surgery may cause drowsiness and a lack of awareness and coordination which could be increased by the use of alcohol or other drugs. I am aware that I should not operate any vehicle or hazardous devices while taking such medications and at least 24 hours after taking them or until recovered from their effects.

I know that some of the above-mentioned complications can be avoided or reduced by carefully following the doctor's instructions. I have had an opportunity to ask questions about the procedure and aspects related to it and have had them answered to my satisfaction. This is my consent to surgery.

Signature

Date

Guardian (if a minor)