DOVE DENTAL
SPECIALISTS

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CONSENT FOR ORAL SURGERY

_____ I hereby authorize
Patient name

_____ and any associates
Doctor name

to perform the following procedure: _____

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment.

The doctor has explained to me that there are certain potential risks in this treatment plan or procedure. These include:

1. Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side; this may persist for several weeks, months,'or in remote instances, permanently.
2. Postoperative infection requiring additional treatment.
3. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
4. Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint.
5. Injury to adjacent teeth and fillings.
6. In rare circumstances, cardiac arrest or breakage of the jaw.
7. Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation.
8. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
9. Stretching of the corners of the mouth with resultant cracking and bruising.
10. _____
_____
_____
_____

Unforeseen conditions may arise during the procedure that require a different procedure than set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgement, they are necessary.

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects.

It has been explained to me and I understand that a perfect result is not guaranteed or warrantied.

Please don't hesitate to ask the doctor or staff if you have any questions.

Email: _____

Phone: _____

_____ _____
Patient Signature Name

_____ _____
Doctor Signature Date