



## CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY AND ANESTHESIA

Patient Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

You have the right to be informed about your condition and the recommended treatment plan, to enable you to make an educated decision as to whether or not to undergo the procedure(s). As with any type of surgery, there are some risks involved. If you have any questions, please ask the doctor before signing.

1. My condition(s) has/have been explained to me as: \_\_\_\_\_  
\_\_\_\_\_
2. The procedure(s) necessary to treat the condition(s) has/have been explained to me and I understand the nature of the treatment to be:  
\_\_\_\_\_  
\_\_\_\_\_
3. I have been informed of possible alternate methods of treatment (if any) including no treatment. I understand that these other treatments or no treatment at all, are choices that I have and the risks of those choices have been presented to me. By signing this form, I authorize Drs. **Nathan, Stark, Frey, B. Robinson, Batrouni, Cohen, Pitts, Kishter, A. Robinson, Carter Robinson, Francioni, Dawood, Habib** and staff to perform the above procedure.
4. My doctor has explained to me that there are certain inherent and potential risks and side effects associated with the proposed treatment(s) and in this specific instance, they include, but are not limited to:
  - A. Post-operative discomfort and swelling which may require additional treatment.
  - B. Prolonged or heavy bleeding which may require additional treatment.
  - C. Injury or damage to adjacent teeth or fillings.
  - D. Post-operative infection that may require additional treatment.
  - E. Stretching of the corners of the mouth which may cause cracking or bruising, and may be slow to heal.
  - F. Restricted mouth opening during healing; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.
  - G. A small piece of root in the jaw may be left if its removal would require extensive surgery or risk of other complications.
  - H. Fracture of the jaw (usually only in more complicated extractions or surgery).
  - I. Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling, or other sensory disturbances in the chin, lip, cheek, gums or tongue which may persist for several weeks, months, or in rare instances, permanently.
  - J. Opening of the sinus (chamber situated above the upper teeth) requiring additional surgery or treatment.
  - K. Dry socket or loss of blood clot from the extraction site.
  - L. Allergic reactions (previously unknown) to any medications used in treatment.
5. It has been explained that during the course of treatment, unforeseen conditions may be revealed that may require changes in the procedure noted in item 2 above. In this instance, I authorize my doctor and staff to use professional judgment to perform additional procedures they deem necessary and desirable to complete my surgery.
6. If you have been treated previously with bisphosphonate drugs (Fosamax, Boniva, Aredia, Reclast, etc.), you should know that there is a significant risk of future complications associated with dental treatment. These drugs appear to adversely affect bone healing in the jaw. This risk is increased after surgery, especially from extraction, implant placement or other procedures that might cause even mild trauma to bone. Osteonecrosis may result. This is a long-term destructive process in the jawbone that is often very difficult or impossible to eliminate.

7. The anesthetic I have chosen for my surgery is:

\_\_\_\_\_ Local Anesthesia only

\_\_\_\_\_ Local Anesthesia w/ non-intravenous sedation (nitrous oxide and/or oral medications)

\_\_\_\_\_ Local anesthesia with Intravenous (IV) sedation/anesthesia

**8. ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness, dizziness, nausea, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered very safe, does carry with it the extremely rare risks of heart irregularities, heart attack, stroke, brain damage or even death.

9. **YOUR OBLIGATIONS IF INTRAVENOUS ANESTHESIA IS USED** (SEDATION OR GENERAL ANESTHESIA):

A. Since anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you have sufficiently recovered to care for yourself. This may take up to 24 hours.

B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

C. Prior to the procedure, you must have a completely empty stomach. IT IS IMPORTANT THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!

D. However, if you are taking any regular medications (e.g. high blood pressure, antibiotics, etc.) it is **IMPORTANT** that you take these medications or any medications provided by this office, by **using only a small sip of water.**

10. It has been explained to me, and I fully understand that a perfect result is not or cannot be guaranteed. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that treatment would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment. I agree to cooperate completely with the recommendations of Drs. Nathan, Stark, Frey, B. Robinson, Batrouni, Cohen, Pitts, Kishter, A. Robinson, Oswald, Carter Robinson, Francioni, Bae, Dawood. I realize that a lack of cooperation may result in a less than optimal result.

11. I certify that I speak, read and write English and have read and fully understand this consent for surgery. I have had my questions answered by my doctor or his/her staff and that all blanks were filled in prior to my signature.

**PLEASE ASK THE DOCTOR OR ANY OF THE STAFF IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT FORM.**

I hereby acknowledge that I have read the foregoing, have discussed any questions or concerns I may have regarding my proposed treatment, and that I may request a copy of this form.

**Patient's (or authorized guardian) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient's (or authorized guardian) Name (print):** \_\_\_\_\_

**If authorized guardian, relationship to patient:** \_\_\_\_\_

**Doctor's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_