NOSE

CREEK

DENTAL

CENTRE

#1, 409 – 1 Avenue

Airdrie, AB T4B 3E2

(403)948-6684

Informed Consent for Oral Surgery

Patient Name: _____ Date: _____

Are you taking blood thinners or aspirin Y/N
Have you ever taken bone density medication? Y/N
If yes: For how long? _____
Has it been more than five years since you have taken bone density Medication Y/N

This is my consent for your dentist to perform the following treatment / procedure / surgery:

_____

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

I understand that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks may include, but are not limited to the following:

1. Postoperative discomfort, bruising and swelling that may necessitate several days of recuperation.
2. Injury to adjacent teeth, crowns or fillings.
3. Postoperative infection, dry socket or delay in healing requiring additional treatment.
4. Stretching of the corners of the mouth with resultant cracking and bruising.
5. Restricted mouth opening for several days or weeks, discomfort in jaw joints.
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
7. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operative side. This may persist for several weeks, months or in rare instances permanently.
8. Opening of the sinus (a normal cavity situated above the upper teeth) which may require additional surgery.
9. Breakage of the jaw.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Because of individual patient differences, there exists a risk of failure, relapse or worsening of my present condition despite the care provided. Selective re-treatment may be necessary. However, I accept the doctor's opinion that therapy would be helpful for my oral health, and that without treatment my oral condition may otherwise worsen with risks to my health including, but not limited to, swelling, pain, infection, cyst/tumor formation, periodontal (gum) disease, dental caries, malocclusion, pathologic fracture of jaw, premature loss of teeth and/or premature loss of bone.

I have had the opportunity to discuss with the doctor my past medical and health history (including any serious problems and/or injuries) and any other concerns regarding proposed treatment.

I agree to cooperate completely with the recommendation of the doctor while I am under his/her care, realizing that any lack of same could result in less than optimal result.
I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO TREATMENT, AND THAT THE EXPLANATION THEREIN REFERRED TO WERE IN FACT MADE TO ME, AND THAT THE FORM WAS FILLED IN PRIOR TO TREATMENT.

_____ _____

Signature of Patient/Parent or Guardian Dentist