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INFORMED CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY

Patient Name _____ Date _____

Procedure(s): Surgical removal of tooth name/number(s): _____

Alternative to surgery, risks to my health if the above procedure is not performed include but are not limited to:

Please check as you read.

- ◯ Infection.
- ◯ Cyst or tumor formation.
- ◯ Periodontal (gum) disease.
- ◯ Increased risk for complications if removal is required at a later time.

Possible complications which have been discussed with me include but are not limited to:

Please check as you read.

- ◯ Injury to the nerves, to the lower lip, and tongue causing numbness which could be permanent.
- ◯ Bleeding and/or bruising which may be prolonged.
- ◯ Dry socket.
- ◯ Involvement in the sinus above the upper teeth.
- ◯ Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and increased risk of complications.
- ◯ Injury to adjacent teeth or fillings.
- ◯ Unusual reaction to medications given or prescribed.
- ◯ Additionally _____

I understand that a perfect result cannot be guaranteed. If any unforeseen conditions arise during the procedure, I request and authorize the Doctor to do whatever he deems advisable to correct the condition.

I agree to cooperate completely with Dr. Jess Chhokar, and will follow post-operating instructions to the best of my ability for my own comfort and safety. I have had the opportunity to ask questions concerning this procedure.

X _____ X _____
Signature (Patient/Parent/Legal guardian) Date

X _____ X _____
Signature (Dentist) Date