Auburn Oral Surgery & Implant Center

#  **Diplomates American Board of Oral & Maxillofacial Surgery**

**Fellows of the American Association of Oral & Maxillofacial Surgeons**

Consent for Oral Surgery and Anesthesia

# Current standard of care in oral surgery practice requires that I obtain your informed consent prior to performing oral surgery and the administration of anesthesia. What you are being asked to sign is a confirmation that I have discussed your contemplated procedure, and I have informed you of all risks, benefits, and ramifications of this procedure, all alternative treatments with their risks and benefits.

**I authorized Dr. Azzouni /Dr Babameto (herein referred as “the dentist”) to treat the following** :

|  |
| --- |
| **Diagnosis:** |

|  |
| --- |
| **Procedure:** |
|  |
|  |

|  |
| --- |
| **Alternatives**: |

1. I also authorize the dentist to perform any additional procedure(s) deemed necessary in his judgment to accomplish an optimal result. I consent to the administration of local anesthesia and/or general anesthesia (if deemed necessary) or any medication deemed necessary by the dentist before, during or after surgery.
2. I understand that there are possible side effects or allergic reactions to any medication including nausea, vomiting, constipation, dizziness, itching, hives, swelling of tongue, lips or face, breathing difficulty, and cardiac arrest (death). I understand there is a greater risk of complications with general anesthesia than with local anesthesia.
3. If undergoing general anesthesia, I agree not to have had anything to eat or drink for at least six hours before surgery; I agree to have a responsible adult drive me home; I agree not to drive or operate a machine for at least 24 hours after surgery. I understand failure to comply with the above could be life threatening.
4. I understand these are possible risks of the procedures:

A.--------Pain, discomfort, bruising, bleeding, swelling, sore throat or difficulty swallowing, (any or all possibly severe at times) necessitating

 several days or weeks of home recuperation.

 B---------Stretching or abrasion of the lips or corners of the mouth resulting in soreness, pain, difficulty opening, and eating – (lasting several

 days or weeks.).

 C---------Swallowing or aspiration (breathing in) of part of a tooth, filling or debris.

 D---------Injury to adjacent teeth and gums or loss or loosening of fillings and caps.

 E---------Sensitivity of adjacent teeth to cold food and liquids for weeks or months.

 F---------Trismus (restricted mouth opening) lasting several days or weeks.

 G---------Postoperative infection possibly severe requiring hospitalization.

 H---------Bone spicules (particles) or sharp edge of bone or food debris causing irritation, pain, swelling or infection presenting days or weeks

 after surgery.

 I----------Dry socket or painful socket requiring days or weeks of dressing changes.

 J----------Numbness (loss of feeling) of the lip(s), chin, cheek(s), face, gums, and/or tongue with loss of taste, that usually resolves in weeks or

 months but could remain permanently.

 K---------For upper teeth—opening into the sinus or nasal cavity or sinus complications or infection possibly requiring a second procedure

 possibly with additional costs.

 L---------Decision to leave small root tip in the jaw when its removal could damage the nerve or the sinus.

 M--------If intravenous used, soreness, swelling, bruising, infection or phlebitis (inflammation at the injection site or along the course of the

 vein).

 N--------Temporomandibular joint (jaw joint) dysfunction and pain.

 O--------Weakening or fracture of the jaw or part of the jaw (alveolar process, tuberosity) surrounding the tooth.

 P--------Other:

I certify that the medical history I have given is accurate and complete to the best of my knowledge. I understand that the practice of oral surgery is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the procedure. I realize in spite of the possible complications, my contemplated surgery is necessary and that I understand all the risks and benefits and ramifications of this procedure and of all alternative treatments, including the option of doing no treatment at all. I agree to follow all of the dentist’s instructions and recommendations. I agree to contact the office at any time, day, night or weekend for any problem (e.g. As in #2 and #4) during and after my postoperative period. **I certify that I have read and fully understand this consent for surgery and all questions about the procedure have been answered to my satisfaction.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **PATIENT** | **PARENT OR LEGAL GUARDIAN** | **DATE** |
|  |  |  |
| **WITNESS** | **DOCTOR’S SIGNATURE** | **DATE** |