INFORMED CONSENT FOR ORAL-MAXILLOFACIAL SURGERY AND ANESTHESIA**

The undersigned herewith permits and consents to the performance of the treatment and/or procedure known as ____

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for patient ____

by Dr. Mark S. Greskovich, and/or Dr. Kevin C. Dean, and/or____________________, and the administration of local and/or general anesthesia, sedation, or analgesia. The undersigned has been explained and understands that the following conditions, side effects and complications have been known to be associated with or follow this type of treatment and anesthesia: death or brain damage; prolonged and heavy bleeding; pain; infection; swelling; temporary, persistent or permanent numbness, dysesthesia, and tingling of the lip, chin and/or tongue; loss of taste; jaw fracture; loosening or injury to adjacent teeth and dental restorations; vein inflammation, if intravenous medications are used; displacement of teeth or foreign bodies into nearby tissues, spaces and cavities; root fractures; bone splinters; sinus openings and/or infections; medication reactions; spasm of the neck, facial and jaw muscles; tightness of or injury to the jaw joints; change in bite and other unexpected conditions, side effects and complications. __________

I understand that the above mentioned conditions, side effects and complications occur in frequencies that range from common, as in the case of pain and swelling, to occasional, as in the case of infection or numbness, to extremely rare, as in the case of fractures and most others. I understand and agree that if any of these conditions, side effects and complications or others arise, there may be additional treatment necessary, interference with employment obligations, and additional medical expense. __________

If undergoing intravenous, nitrous oxide, or general anesthesia, I understand that I should have nothing to eat or drink for 8 hours prior to surgery. TO DO OTHERWISE WOULD BE LIFE THREATENING! However, it is important to take any scheduled medications (high blood pressure, antibiotics, etc.) or any prescription the doctor may have provided for premedication using only a small sip of water. __________

I understand that the Alabama and Florida Medical Consent Laws require my doctors to advise me of the general nature of the treatment or procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures. I understand that one alternative is not to have any treatment at all, and I understand the risks and hazards of declining treatment. I also may seek a second opinion or select another doctor. In signing this consent form, I am agreeing that my doctors have advised me of these matters to my satisfaction. __________

I understand that my doctors will provide me with various prescription medications that must be taken responsibly and as prescribed. I also understand that any other drugs, whether prescribed by another doctor or taken recreationally and/or illegally can pose serious risk to my health including death. I have disclosed to my doctor all drugs that I am now taking or have taken and discussed them appropriately with him. I understand and will carefully follow all instructions I receive from my doctor and his staff for any medications that may be prescribed or administered. I understand most of all that if anything unusual or abnormal occurs before or after any treatment while I am a patient of any of the above doctors, I will immediately contact and fully advise my doctor or his staff of this problem. __________

(CONTINUED ON BACK)

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______ It has been explained to me, and I understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed.

______ I understand that the intention of Dr. Mark S. Greskovich, and/or Dr. Kevin C. Dean, and/or____________________, is to relieve me of pain and suffering or to correct a disease or a potential disease or pathologic condition. The benefits of the proposed treatment outweigh the possible complications mentioned above. I have voluntarily signed this consent for treatment, and agree to save harmless and not hold accountable, Drs. Mark S. Greskovich, Kevin C. Dean, and/or Dr. J. Stevens Cotten, and/or Dr. Tyler Smoot, for any treatment that, regardless of his (their) effort to satisfy me, may produce a less than perfect result.

______ I understand that I am free to choose an oral-maxillofacial surgeon to treat me who doesn't require compliance with the Alabama and Florida Medical Consent Laws. I understand and read the English language. I am mentally and physically competent to understand this form and have not taken any mood or mind-altering drugs during the twelve hours prior to signing this document.

______ I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals. By consenting to these medical photographs I understand that I will not received payment from any party. Refusal to consent to photographs will in no way affect the medical care I will received. If I have any questions or wish to withdraw my consent in the future I may contact the office manager.

______ I understand also that I may and should, if I have any doubt at any time before or during treatment and recovery, seek a second opinion of any other doctor.

______ I understand this informed consent for oral maxillofacial surgery and anesthesia and have been given a copy of the pre and post operative instructions.

______________________________ ____________ ______________________________
Patient, Parent or Guardian Date Witness

____
Relationship to Patient

______________________________ ____________ ______________________________
Doctor Date Witness

**Patient, parent or guardian is to initial each paragraph after reading.