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 _____

_____

_____

for patient _____

by Dr. Mark S. Greskovich, and/or Dr. Kevin C. Dean, and/or Aaron C. Wallender, D.D.S., M.D. 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

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INFORMED CONSENT FOR
ORAL-MAXILLOFACIAL SURGERY AND ANESTHESIA**

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.

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 _____, 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 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.

PATIENT ORIENTATION AND CONSENT FORM FOR ENDOSSEOUS IMPLANTS**

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

_____

_____

for patient _____

_____ by Dr. Mark S. Greskovich, and/or Dr. Kevin C. Dean, and/or Dr. Aaron C. Wallender, and/or Oral-Maxillofacial Surgery Associates, P.A., and the administration of local and/or general anesthesia, sedation, or analgesia.

_____ I have been informed and I understand the purpose and the nature of the implant surgery procedure. I understand that incisions will be made inside my mouth for the purpose of placing one or more endosseous structures (implants) in my jaw to serve as anchors for a missing tooth or teeth replacement or to stabilize a crown (cap), bridge or denture. I acknowledge that the doctor has explained the procedure, including the number and location of the incisions and the type of implants to be used. I understand that the crown, bridge or denture that will later be attached to the implant(s) will be made and attached by Dr. _____ and that a separate charge will be made by that office.

_____ I understand that the implant(s) must remain covered by gum tissue for at least three or four months before being used. No guarantee can be or has been given that the implant(s) will last for a specific time period. It has been explained to me that once the implant(s) is/are inserted, the entire treatment plan must be followed and completed on schedule. If the planned schedule is not carried out, the implant(s) may fail.

_____ Dr. Mark S. Greskovich, and/or Dr. Kevin C. Dean, and/or Dr. David T. Turbyfill have carefully examined my mouth. Alternatives to this treatment have been explained. I have tried or considered these methods, but I desire an implant to help secure the replaced missing teeth.

_____ I have further been informed of the possible complications and risks involved with surgery, drugs, and anesthesia. Such complications include pain, loss of taste, swelling, infection, and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may also occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation of the vein, injury to teeth present, bone fractures, sinus penetration, delayed healing, and allergic reactions to drugs and medication used. I also understand that there are multiple small instruments and implant parts and that it is possible to swallow or aspirate implant parts. I also understand that if this happens, a normal medical protocol will be followed, possibly involving abdominal and chest x-rays and possible further need for surgical removal of the foreign body.

_____ I understand that if nothing is done, any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity or looseness of teeth, followed by necessity of extraction, temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, and tired muscles when chewing.

_____ Dr. Mark S. Greskovich, and/or Dr. Kevin C. Dean, and/or Dr. David T. Turbyfill, have explained that there is no method to accurately predict the gum and bone healing capabilities in each patient following the placement of the implant.

_____ It has been explained that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science: no guarantees or assurance as to the outcome of results of treatment or surgery can be made.

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PATIENT ORIENTATION AND CONSENT FORM FOR ENDOSSEOUS IMPLANTS**
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_____ I understand that excessive smoking, alcohol, or sugar may affect the gum healing and may limit the success of the implant. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

_____ I understand that certain anesthetic risks, which could involved serious bodily injury, coma, or death are inherent in any procedure that requires general anesthesia, sedation, and analgesia.

_____ To my knowledge I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding, or any other conditions related to my health.

_____ I consent to photography, filming, recording and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.

_____ I request and authorize medical/dental services for me, including implants and other surgery. I fully understand that during and following the complicated procedure, surgery or treatment, conditions may be apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modification in design, material or care, if it is felt this is for my best interest.

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

_____ I understand that I am free to choose an oral/maxillofacial surgeon to treat me who does not require compliance with the Florida and Alabama Medical Consent Laws. I am medically 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 consent.

_____ I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULL UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE THAT I READ AND WRITE ENGLISH.

_____	_____	_____
Patient, Parent or Guardian	Date	Witness
_____	_____	_____
Doctor	Date	Witness

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