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OROFACIAL PROFESSIONALS

CONSENT FOR ORAL SURGERY

Orofacial professionals will provide you with the necessary information and advice, which would facilitate in proper decision process.

This form will acknowledge your consent to treatment, recommended by your doctor

I understand that there are potential risks, complications and side effects associated with any dental procedure. I have been informed of the possible risks, complications and side effects of oral surgery.

- Post operative discomfort and swelling.
- Bleeding
- Delayed healing
- Post operative infection
- Injury or damage to adjacent teeth or roots of the teeth.
- Injury or damage to nerve in the lower jaw, causing temporary or permanent numbness and tingling of the chin, lips, cheek, gums or tongue.
- Restricted ability to open the mouth because of swelling because of muscle soreness or stress on the jaw joints
- Bone loss of the jaw
- Penetration into the sinus cavity.
- Failure of the implant
- Allergic or adverse reaction to any medications.

Most of these risks, complication and side effects are not serious or do not happen frequently but although these risks, complications and side effects may occur only rarely, they do sometimes occur and cannot be predicted or prevented by the dentist performing the procedure.

Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

These potential risks and complications could result in the need to repeat the procedure; remove the implants; or undergo additional dental, medical or surgical treatment or procedures.

I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures. I request and authorize my dentist to perform such treatment or procedures as required.

Signature of patient_____ Date_____