MASON & MASON
DENTISTRY PA

Informational Informed Consent for Oral Surgery

I understand that the purpose of the procedure/surgery is to treat and possible correct my diseased oral/maxillofacial tissues. The Doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time, and the risks to my health may include, but are not limited to, the following: swelling, pain, infection, cyst formation, periodontal (gum) diseases, dental decay, malocclusion (bad bite), fracture of the jaw, premature loss of teeth and/or premature loss of bone. I have been informed of the possible alternative methods of treatment, if any, and I have been told that one of my alternative choices is to have NO TREATMENT.

The Doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to:

- Postoperative discomfort and swelling that may necessitate several days of recuperation.
- Heavy and prolonged bleeding.
- Injury to adjacent teeth and fillings.
- Postoperative infection requiring additional treatment.
- Stretching of the corners of the mouth with resultant cracking and bruising.
- Restricted mouth opening for several days or weeks.
- Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
- Breakage of the jaw.
- Injury to a nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, and/or tongue on the operative side. This may persist for several weeks, months, or permanently.
- Opening of the sinuses (normal cavity situated above the upper teeth) requiring additional surgery at additional cost.
- Other _____

The Doctor and I have discussed these risks and benefits of treatment and I have had an opportunity to ask questions and share my concerns with the Doctor.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition despite the care provided. However, it is the Doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I have had the opportunity to discuss with the Doctor my past medical and health history including any serious problems and/or injuries.

I agree to cooperate completely with the recommendation of the Doctor while I am under his care, realizing that any lack of same could result in a less than optimum results.

_____

Patient's name (please print)

_____ _____

Signature of patient, legal guardian or authorized representative Date

Tooth No.(s) _____ _____ _____ _____

_____ _____