CONSENT FOR ORAL SURGICAL PROCEDURES

You have the right to be informed about your condition and the recommended treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to provide information so that you may give or withhold your consent.

_____ _____

Patient's Name Date

The procedure(s) necessary to treat my conditions(s) has/have been explained to me and I understand the nature of the treatment to be:

_____

I understand that these other forms of treatment, or no treatment at all, are choices that I have and the risks of those choices have been presented to me.
My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment and in this specific instance they include but are not limited to:

- Post-operative discomfort and swelling that may require several days of at-home recovery.
- Prolonged or heavy bleeding that may require additional treatment.
- Injury or damage to adjacent teeth or fillings.
- Post-operative infection that may require additional treatment
- Stretching of the corners of the mouth that may cause cracking or bruising and may heal slowly.
- Restricted mouth opening during healing, sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ) especially when TMJ problems already exist.
- A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
- Fracture of the jaw (usually only in more complicated extractions or surgery).
- Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums or tongue and which may persist for several weeks, months or, in rare instances, permanently.
- Opening of the sinus (a normal chamber situated above the upper back teeth) requiring additional surgery or treatment.
- Dry socket (loss of blood clot from extraction site).
- Allergic reactions (previously unknown) to any medications used in treatment

It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted above. I authorize that my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

The anaesthetic I have chosen for my surgery is:

- ☐ Local Anaesthesia
- ☐ Local Anaesthesia with Intravenous Sedation.

ANAESTHETIC RISKS include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting although uncommon, may be unfortunate side effects of IV anaesthesia. Intravenous anaesthesia is a serious medical procedure and, although considered safe, does carry with it the rare risks of heart irregularities, heart attack, stroke, brain damage or even death.

YOUR OBLIGATIONS IF AN IV ANAESTHETIC IS USED:

- Because anaesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be 24 to 48 hours or longer.
- During recovery time (48 hours or longer) you should not drive, operate complicated machinery or devices or make important decisions such as signing documents, or drink alcohol, etc.
- You must have a completely empty stomach. It is vital that you have had nothing to eat eight (8) hours prior or drink for six (6) hours prior to your anaesthetic**. To do otherwise may be life threatening!**
- However, it is important that you have taken any regular medications (high blood pressure antibiotics, etc.) or any medications provided by this office, using only a small sip of water.

I certify that I have read and fully understand this consent for surgery, have had my questions answered and that all blanks were filled in prior to my signature.

It is important to note that medications typically taken for osteoporosis, certain cancers as well as other disorders (bisphosphonates or other types of medication) such as Fosamax or Prolia may NOT allow proper healing and may cause additional damage to my bone and teeth.

No Warranty or Guarantee. I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

Publication of Records. I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

Governing Law. I agree that the relationship between me and the dentist shall be governed and construed in accordance with the laws of the province of Ontario.

Jurisdiction. I acknowledge that the treatment /service is to be performed in the province of Ontario, and agree that the courts of the province of Ontario shall have exclusive jurisdiction to adjudicate any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment.

Please ask your Doctor if you have questions concerning this consent form.

_____ _____

Patient's (or legal guardian's) signature Date