



ORAL SURGERY AND DENTAL EXTRACTIONS INFORMED CONSENT

For _____

I understand that oral surgery and dental extractions include inherent risks, including but not limited to the following:

1. *Injury to the nerves.* A possible consequence of surgical procedures or anesthetic administration is injury causing numbness of the lips and tongue as well as any tissues of the mouth, cheeks, and/or face. This numbness may be of a temporary nature, lasting a few days, weeks, or months, or could possibly be permanent.
2. *Bleeding, bruising, and swelling.* Some moderate bleeding may last several hours. If bleeding is profuse, the office should be contacted as soon as possible. Likewise, some swelling is normal, but if it is severe, the office should be notified. Swelling usually starts to subside after about 48 hours. Bruises may persist for a week or more.
3. *Dry socket.* Dry socket sometimes occurs when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry socket can be extremely painful if not treated.
4. *Sinus involvement.* In some cases, the root tips of upper teeth lie in close proximity to the maxillary sinus. Occasionally during extraction or surgical procedures, the sinus membrane may be perforated. Should this occur, it may be necessary to have the sinus surgically closed. Root tips may need to be retrieved from the sinus.
5. *Infection.* No matter how carefully surgical sterility is maintained, it is possible, because of the existing nonsterile oral environment, for infections to occur postoperatively. At times, these may be serious in nature. Should severe swelling occur, particularly if it is accompanied with fever or malaise, professional attention should be sought as soon as possible.
6. *Fractured jaw, roots, bone fragments, or instruments.* Although extreme care will be used, the jaw, tooth roots, bone spicules, or instruments used in the extraction procedure may fracture, requiring retrieval and possibly referral to a specialist. A decision may be made to leave a small fragment of root, bone, or instrument in the jaw when removal may require additional extensive surgery, which could cause more harm and add to the risk of complications.
7. *Injury to adjacent teeth or fillings.* Injury to adjacent teeth or fillings may occur no matter how carefully surgical and/or extraction procedures are performed.
8. *Bacterial endocarditis.* Because of the normal existence of bacteria in the oral cavity, bacterial infection may be transmitted through blood vessels to the tissues of the heart, and bacterial endocarditis (an infection of the heart) could occur. It is the patient's responsibility to inform the dentist of any known or suspected heart problems.
9. *Adverse reactions to medications given or prescribed.* Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Other methods of contraception must be used during the treatment period.

It is my responsibility to seek attention should any undue circumstances occur postoperatively, and shall diligently follow all preoperative and postoperative instructions.

Informed Consent

As a patient, I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risks, including the risk of harm, if any, that may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fees for this service have been explained to me and are satisfactory. I authorize photographs, slides, x- rays, or any other visual records of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. However, my identity will not be revealed to the general public without my permission. By signing this form, I am freely giving my consent to allow and authorize Dr Link and his or her associates to render any treatments necessary or advisable for my dental conditions, including any and all anesthetics and/or medications.

Signature of patient _____ Date _____

Signature of doctor or witness _____ Date _____