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INFORMATION and CONSENT FOR OFFICE SURGERY and ANESTHESIA

Patient's Name_____

I hereby grant permission to perform the below listed procedures. The reason for and nature of this operation have been explained to me. Alternate methods of treatment, if any, have also been explained to me. I have been advised that, although good results are expected, the possibility and nature of all possible complications cannot be accurately anticipated and that, therefore, there can be no guarantees as to the result of the surgery. The following risks are known to be associated with these procedures and have been explained to me:

Pain, Swelling, Bleeding, Infection, Jaw Stiffness,
Nausea, Vomiting, Allergic Reactions.

Others may include:

_____ 1. Postoperative discomfort, prolonged bleeding, and swelling that may necessitate several days home recuperation.
_____ 2. Postoperative infection requiring additional treatment.
_____ 3. Injury to the other teeth and/or fillings.
_____ 4. Stretching of the corners of the mouth with resultant cracking or bruising.
_____ 5. Restricted mouth opening for several days or weeks.
_____ 6. Decision to leave a piece of the tooth in the jaw, sinus or tissues when its removal would require extensive surgery.
_____ 7. Pain and swelling at the IV site with/without discoloration.
_____ 8. Breakage of the jaw.
_____ 9. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin. Gums, cheek, teeth and/or tongue which may persist for several weeks, months or permanently.
_____ 10. Changes in tooth position or bite (Temporomandibular Joint Dysfunction).
_____ 11. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
_____ 12. Dry Socket (localized alveolitis)
_____ 13. Other _____

Procedures

_____ It has been explained to me that , during the course of the procedure(s) unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those explained to me. If such unforeseen condition(s) should arise in the course of the procedure, calling for the dentist's judgment or for the procedures in addition to or different from those now contemplated, I request and authorize the dentist to do whatever he may deem advisable.

The Anesthesia Requested is:

(1) LOCAL (2) I.V. Sedation

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

_____ I consent to the administration of anesthesia, including local, nitrous oxide/oxygen (laughing gas) and/or intravenous sedation in connection with the procedure(s) referred to above, by any of the persons described and to the use of such anesthetics as may be deemed advisable with the exception of: _____ to which I am allergic.

_____ Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile or hazardous device for at lest 24 hours after my release from surgery or until further recovery from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

_____ I have informed Dr. Anthony A. Shaia of my past medical and health history including serious problems and/or injuries.

_____ I understand and agree that I am not to have and/or have not had anything to eat or drink for eight (8) hours prior to surgery.

_____ I agree to cooperate completely with the recommendations of the dentist while I am under his care, realizing that any lack of same could result in less than optimal result.

I certify that I have had an opportunity to read and that I fully understand the terms and words within the above consent and the explanation(s) referred to or made, and that all blanks or statements requiring insertion or completion where filled in and any inapplicable paragraphs, if any, were stricken before I signed. I also state that I read and write English.

_____	_____	_____
Patient	Parent/Guardian	Date
_____	_____	_____
Witness	Dentist	Date