Sheila Harris, D.D.S.

ORAL SURGERY INFORMED CONSENT

The purpose of this Informed Consent Form is to provide an opportunity for patients (and/or their parents or guardians) to understand and give permission for oral surgery. Each item should be checked off after the patient (and/or his/her parents or guardians) has the opportunity for discussion and questions.

_____ **1.** I, THE UNDERSIGNED, CONSENT TO Dr._____, his/her partners and/or associates performing on me the following outlined oral surgery:
_____
_____
as outlined in the treatment plan (*as outlined on the "Treatment Form" that has been provided to me).*

_____ **2.** I accept and understand that this oral surgery can be performed under:

_____a. local anesthesia/injections
_____b. oral sedation
_____c. IV sedation
_____d. general anesthesia

_____ **3.** I accept and understand that I elect to have the above oral surgical procedure under:
_____a. local anesthesia
_____b. oral sedation
_____ c. IV sedation
_____d. general anesthesia

_____ 4. This oral surgery has been fully explained to me, including all risks and complications involved. I have been fully informed that the risks and complications may include, but are not exclusive of:

_____ a. Post-operative discomfort and swelling.
_____ b. Bleeding which may be heavy or prolonged.
_____ c. Injury to adjacent teeth and fillings.
_____ d. Post-operative infection which may require additional treatment.
_____ e. Stretching of the corners of the mouth that may cause cracking and bruising.
_____ f. Restricted mouth opening for several days sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).
_____ g. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery or treatment.
_____ h. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, cheek, gums, tongue, or teeth.
_____ i. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

_____ 5. I acknowledge that the alternatives to this treatment have been discussed with me and I understand these options and the associated consequences.

_____ 6. I have had the opportunity to discuss the oral surgery, and have had an opportunity to ask questions, and am fully satisfied with the answers received.

_____ 7. If, during the procedure, a change in treatment is required, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

Patient's Signature (or Parent/Guardian):_____ Date: _____

Patient's (or Parent/Guardian's) Identification: _____

Witness' Name: _____ Witness' Signature: _____ Date:_____

Doctor's Signature: _____Date: _____