# MARSHALL DENTAL ASSOCIATES

## CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY

**To The Patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is NOT meant to scare or alarm you; it is simply an effort to make you BETTER informed so that you may give or withhold your consent to the procedure.**

**I (WE) voluntarily request Dr. _____ as my doctor, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition which has been explained to me as _____**
**_____**
**_____**

**I (WE) understand that the following surgical, medical and/or diagnostic procedure or procedures are planned for me on or about _____ (months) _____ (day) _____ (year) by or under the direction of Dr. _____**
**I voluntarily consent and authorize this (these) procedure(s): _____**
**_____**
**_____**

**I (WE) authorize this doctor's office to dispose of any surgically removed tissue or parts resulting from said procedures in accordance with accustomed practice.**

**I (WE) understand that Dr. _____ may encounter or discover other or different conditions which require additional or different procedures than those planned. I (WE) authorize Dr. _____ , my doctor, and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgement.**

**I (WE) understand that no warranty or guarantee has been made to me as to result or cure.**

**Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance for the surgical, medical and/or diagnostic procedures planned for me. I (WE) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins or lungs, hemorrhage, allergic reactions and even death. I (WE) also realize that the following risks and hazards may occur in connnection with this (these) procedures:**

**(Please initial each of the circled risks which were discussed.)**

**___ 1. Postoperative discomfort and swelling which may necessitate several days of home recuperation.**

___ 2. **Postoperative infection requiring additional treatment.**
___ 3. **Dry socket.**
___ 4. **Injury to the nerve-underlying the teeth resulting in numbness or tingling of the lip, chin, gums, teeth and/or tongue on the operated side; this may persist for several weeks, months, or in remote instances permanently.**
___ 5. **Opening of the sinus (a normal cavity situated above upper teeth) or sinus infection that may require additional surgery.**
___ 6. **Heavy bleeding that may be prolonged.**
___ 7. **Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.**
___ 8. **Breakage of the jaw.**
___ 9. **Stretching of the corners of the mouth with the resultant cracking and bruising.**
___ 10. **Restricted mouth opening for several days or weeks.**
___ 11. **Injury to adjacent teeth or fillings.**
___ 12. **Injury to the temporo-mandibular joint. (TMJ)**
___ 13. **OTHER:** _____
___ 14. **OTHER:** _____

**I (WE) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (WE) have read it or have had it read to me (us), that the blank spaces have been filled in and that I (WE) understand its contents.**

_____ _____ _____

**Signature of Patient or legally responsible person** **DATE** **TIME**

_____ _____

**Printed name of witness, and position** **Signature of witness**

**I certify the foregoing Consent and Disclosure Statement has been complied with in all respects.**

_____ _____

**Treating Physician** **DATE**