CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY AND ANESTHESIA

Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

I hereby authorize **Dr. Tyler L. Clark** and his staff to perform the following procedure:

_____

and to administer the anesthesia I have chosen, which is:

_____☐ Local Anesthesia
_____☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
_____☐ Local Anesthesia with Oral Premedication
_____☐ Local Anesthesia with Intravenous Sedation

Other treatment options:_____

_____

_____1. I understand that there are known consequences of surgery and the administration of drugs and anesthetics that include (but are not limited to): pain and discomfort, swelling, bleeding, bruising, and infection. Changes in the bite or restricted mouth opening secondary to stress on the jaw joint (TMJ) may occur. There is also the possibility of injury to adjacent teeth or other tissues of the face or mouth, bone/jaw fractures, delayed healing, dry socket, or unexpected drug reactions or allergies.

_____2. With tooth extraction, I understand that there may be unexpected damage to adjacent teeth or fillings, sharp ridges or bone splinters that may require later surgery to smooth or remove, dry socket which will require additional care, or small fragments of tooth root which may be left in place to avoid damage to vital structures such as nerves or sinus.

_____3. Lower tooth roots may be very close to the nerve and surgery may result in pain or a numb feeling of the chin, lip, cheek, gums, teeth or tongue (including possible loss of taste sensation) lasting for weeks, months, or may rarely be permanent. On upper teeth where roots are close to the sinus, a sinus infection may develop, a root tip may enter the sinus and/or an opening from the mouth to the sinus may occur which could require later medication or surgery.

_____4. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) that may cause prolonged discomfort and/or disability, and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the rare risks of heart irregularities, heart attack, stroke, brain damage or death.

_____5. **I UNDERSTAND THAT IF IV ANESTHESIA IS USED:**

A. Because anesthetic medications cause prolonged drowsiness, I **will** be accompanied by a responsible adult to drive me home and stay with me until I'm sufficiently recovered to care for myself. This may be up to 24 hours.
B. During my recovery time **(24 hours)** I will not drive, or operate complicated machinery or devices, or make important decisions such as signing documents, etc.
C. I HAD NOTHING TO EAT OR DRINK FOR **SIX (6) HOURS** PRIOR TO MY ANESTHETIC. **TO DO OTHERWISE MAY BE LIFE-THREATENING!**
D. **HOWEVER,** I have taken my regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water.**

_____6. I understand that no guarantee can be promised, and I give my free voluntary consent for treatment. I realize that my doctor may discover conditions requiring different surgery from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgment.

INFORMATION FOR FEMALE PATIENTS

_____1. I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

Surgical time out _____

CONSENT

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia.
I certify that I speak, read and write English.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date

Print Witness' Name and Address

Unless sooner terminated in writing, this consent shall remain in force for 60 days from the date it is signed by the Patient. A facsimile transmission, and/or an electronic scanned transmission, shall constitute an original. 05/2012