CONSENT FOR UNCOVERING TEETH FOR ORTHODONTIC CARE

Patient's Name Date

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

You have the right to be informed about your diagnosis and planned surgery so that you may make an informed decision as to whether to undergo a procedure after knowing the risks and benefits.

Your diagnosis is:_____
Your planned surgery is:_____
Alternative treatment methods include:_____

It has been explained to me that certain risks and complications are associated with my surgery, which include (but are not limited to):

_____1. Swelling, soreness, bruising, stiffness of jaw muscles and jaw joints (TMJ), unexpected drug reactions or allergies, and fracture of the jaw or portions of bone supporting teeth, and difficulty eating for a number of days.

_____2. Because of the exposure required to gain access to certain teeth buried beneath the gum, areas around the uncovering may feel numb for days, weeks or months after surgery. In rare cases this feeling may be permanent.

_____3. Certain teeth to be uncovered often are very close to roots of adjacent teeth. There is a slight chance that those roots may be injured, requiring later root canal treatment or, in rare instances, may result in the loss of those teeth.

_____4. Although usually only one incision is needed to expose the buried tooth, sometimes the approach is complicated enough to require two or more incisions.

_____5. When uncovering upper back teeth, there is a chance that the sinus may be entered, requiring antibiotic therapy, or possibly resulting in an opening between mouth and sinus that may require further care. Rarely, the same complication may affect the nasal cavity.

_____6. Often an orthodontic bracket and/or a wire or fine chain is attached to the uncovered tooth; then to your orthodontic appliances to gain the force to try to move the tooth. This may cause irritation to your tongue and interfere somewhat with eating. You will usually adjust to this problem fairly quickly. Occasionally the bracket will become detached and must be re-attached.

_____ 7. Although it cannot be easily determined beforehand, sometimes the planned orthodontic movement of the uncovered tooth cannot be accomplished. If so, the tooth may be left in place or, if conditions require, be removed.

_____8. **ANESTHESIA**

The anesthetic I have chosen for my surgery is:

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

_____9. **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 rare, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

_____10. **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.**

_____11. No guaranteed or warranted results have been offered or promised. I realize my doctor may discover conditions that may require a different surgery from that which was planned, and I give my permission for those other procedures that are advisable in the exercise of professional judgment to complete my surgery.

Surgical time out _____

CONSENT

I have had an opportunity to have all my questions answered by my doctor and I certify that I speak, read and write English. My signature below signifies that I understand the surgery and anesthetic that is proposed for me, together with the known risks and complications associated. I hereby give my consent for such surgery and the anesthesia I have chosen.

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