Informed Consent For Oral Surgery & Anesthesia (Page 1 of 3)

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

Patient's Name: _____ Date:_____

____1. This is my consent for Dr. Koos, Dr. Hanson, and/or any oral and maxillofacial surgeon and assistants working with them to treat the following condition(s). _____
_____
_____
_____

____2. The procedure(s) necessary to treat the conditions have been explained to me and I understand the nature of the procedure to be:_____
_____
_____
_____

____3. I understand that the purpose of the elective procedure/surgery is to treat and possibly correct my diseased oral/maxillofacial tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen with time, and the risks to my health may include, but are not limited to the following: swelling, pain, infection, cyst or even tumor formation, periodontal (gum) diseases, dental caries, malocclusion, pathologic fracture of the jaw, premature loss of teeth and/or bone. I have been informed of the possible alternative methods of treatment, if any.

____4. I further understand that this is an elective procedure and other forms of treatment or no treatment at all are choices that I have.

____5. The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that the risks of oral and maxillofacial surgical procedures include, but are not limited to:

A. Post-operative discomfort and swelling that may necessitate several days of home recuperation.
B. Heavy bleeding that may be prolonged and require additional treatment.
C. Injury to adjacent teeth and fillings requiring further treatment.
D. Post-operative infection requiring additional treatment.
E. Stretching of the corners of the mouth with resultant cracking, bruising and sores.
F. Restricted mouth opening for several days or weeks.
G. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
H. Breakage of the jaw.
I. Injury to the nerves underlying the teeth resulting in numbness, tingling or pain of the lip, chin, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months, or in rare circumstances be permanent.
J. Opening of the sinus (a normal cavity situated above the upper teeth) or displacement of tooth roots or teeth into the sinus requiring additional surgery.
K. If intravenous medication is used, soreness at the injection site or along the vein may develop, as well as discoloration of the injection site and possible vein inflammation.
L. Temporo-mandibular joint (TMJ) and muscle spasms problems can occur after oral maxillofacial surgical procedures which may require additional treatment(s). Earaches and worsening of pre-existing TMJ problems can occur as well.
M. I understand that certain anesthetic risks, which could cause serious bodily injury, including cardiac arrest, are inherent in any procedures that require general anesthesia or sedation.
N. Other: _____

oral surgery & implant studio

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____6. I agree and understand that I am not to have and/or have not had anything to eat or drink for six hours before my surgery if general anesthesia or sedation are to be used.

____7. I consent to the administration of anesthesia, including local, intravenous, inhalation, and/or general anesthesia in conjunction with the procedure(s) referred to above and to the use of such anesthetics as may be deemed advisable by Dr. Koos and his associates or assistants. I understand that all anesthetics or sedation medications involve the very rare potential of risks or complications such as damage to vital organs like the brain, heart, lungs, liver and kidneys; paralysis; cardiac arrest; and/or death from both known and unknown causes.

____8. Medication, 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 devices, or work, while taking such medications and/or drugs until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four hours after my release from surgery or until further recovered 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.

____9. No guarantee or assurance has been given to me that the purposed treatment will be curative and/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 doctor's opinion that therapy would be helpful, and that worsening of my condition could occur without the recommended treatment.

____10. I have had the opportunity to discuss with the doctor my past medical and health history including any serious problems and/or injuries.

____11. I agree to cooperate completely with the recommendations of the doctor while I am under his care, realizing that lack of the same could result in a less than optimum result.

____12. I agree to grant consent to any and all additional procedures necessary, either elective or emergent, that may arise during or after my surgery, while I am physically unable to grant consent due to anesthesia or impairment, in order to complete treatment or to treat a complication that has arisen during surgery or anesthesia.

____13. The fee for services has been explained to me and is satisfactory.

____ 14. I certify that I have read or had read to me the contents of this form. I have read or had read to me and will follow any patient instructions related to this procedure. I understand the potential risks, complications and side effects involved with any oral surgery treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

____ 15. I request and authorize medical/dental services for myself, including dental implants and other surgery. I fully understand the contemplated procedure, surgery, or treatment conditions that may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I also approve any modifications in design, materials, or care, if it is felt this is for my best interest. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated I further authorize and direct my doctor, associate or assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the procedure.

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____16. I consent to photography, filming, recording, x-rays, and additional professional staff observing the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.

____ 17. I certify that I speak, read and write English and as such, have read and fully understand this consent for surgery.

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

Doctor's Signature:_____ Date:_____

Witness' Signature:_____ Date:_____