

CONSENT FOR ORAL SURGERY AND ANESTHESIA

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PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTION, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

You have the right to be informed about your condition and the recommended treatment plan to be used so that you may make an informed decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to properly inform you so that you may give or withhold your consent.

PATIENT NAME: _____

DATE: _____

1. This is my consent for Dr. Soto and any other agents, assistants or employees selected by him to perform the following treatment/procedure/surgery.

2. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time, and the risks to my health may include; but are not limited to the following: swelling, pain, infection, cyst formation, periodontal (gum) disease, dental caries, malocclusion, pathologic fracture of jaw, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

3. I have been informed of possible alternative methods of treatment (if any) including:

_____. I understand that other forms of treatment or no treatment at all are choices that I have had and the risks of those choices have been presented to me.

4. Dr. Soto has explained to me that there are certain inherent and potential risks/side effects in any treatment plan or procedure, and that in this specific instance such risks include, but are not limited to the following:

- A. Postoperative discomfort and swelling that may necessitate several days of at home recuperation.
- B. Heavy bleeding that may be prolonged and may require additional treatment.
- C. Injury to adjacent teeth and fillings.
- D. Postoperative infection requiring additional treatment.
- E. Stretching of the corners of the mouth with resultant cracking and bruising and may heal slowly.
- F. Restricted mouth opening for several days or weeks, sometimes related to swelling and muscle soreness and sometimes related to stress on the joints of the jaw (TMJ). Additionally meniscal displacement is possible with subsequent clicking.
- G. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
- H. Fracture of the jaw.
 - I. Injury to the nerve under the teeth resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue on the operated side; this may persist for several weeks, months, or in rare instances, permanently.
 - J. Opening into the sinus (a normal cavity situated above the upper teeth) requiring additional treatment.
 - K. Aspiration.
 - L. Other: _____

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5. It has been explained to me that during the course of the procedure(s) unforeseen conditions may be revealed which will necessitate extension of the original procedure(s) or different procedure(s) from those set forth in Paragraph 2, above. I authorize my doctor and his staff to perform such procedure(s) as are necessary and desirable in the exercise of professional judgment.
6. I agree and understand I am not to have and/or have had anything to eat or drink for 6 to 8 hours before my surgery. **TO DO OTHERWISE MAY BE LIFE THREATENING!**
7. Medications, 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 to return to work, while taking such medications and/or drugs, or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four (24) 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 at the time of surgery, 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.
8. I understand that certain anesthetic risks which could involve serious bodily injury, are inherent in any procedure that requires a general or intravenous anesthetic. I consent to the administration of **LOCAL / IV SEDATION / NITROUS / GENERAL ANESTHESIA. (Circle choice)**
9. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever deemed advisable.
10. No guarantee or assurance has been given to me that the proposed 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 a worsening of my condition would occur sooner without the recommended treatment.
11. I have had an opportunity to discuss with Dr. Soto my past medical and health history including any serious problems and/or injuries.
12. I agree to cooperate completely with the recommendations of Dr. Soto while I am under his care, realizing that any lack of same could result in a less than optimum result.
13. It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will use an additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT AND THE EXPLANATION MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ANY APPLICABLE PARAGRAPHS WERE STRICKEN BEFORE I SIGNED. I ALSO STATE I SPEAK, READ, AND WRITE ENGLISH AND CAN PLAINLY SEE THESE WORDS WHICH I AM READING.

PATIENT'S (OR LEGAL GUARDIAN'S) SIGNATURE

DATE

WITNESS' SIGNATURE

DATE

DOCTOR'S SIGNATURE

DATE