



HENRIETTA FAMILY DENTAL
IMPLANT & DENTAL CARE

CONSENT FOR ORAL SURGERY AND ANESTHESIA

Page 1 of 4

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 can Decide whether to have a procedure or not, after knowing the risks and benefits.

Your diagnosis is: _____

Your planned treatment is: _____

Alternative treatment methods include: _____

Whether a procedure is easy or difficult, it is still a surgical procedure. All surgeries have some risks. They include the following, but are limited to:

- ___ 1. Swelling, bruising and pain.
- ___ 2. Possible infection that might need more treatment.
- ___ 3. Changes in the bite or difficulty in opening the mouth because of stress on the jaw joint (TMJ) may happen.
- ___ 4. Possible damage to other teeth close to the ones being taken out, (more often those With large fillings or caps), or other tissues of the face or mouth might be harmed.
- ___ 5. It is very rare that the bones of the jaw will break, but it is possible in cases where the Teeth are buried very deep in their sockets.
- ___ 6. Healing could take longer.
- ___ 7. The place where the tooth was taken out could be very painful (dry sockets).
- ___ 8. I might have a reaction to medicine.
- ___ 9. Sharp ridges or bone splinters may form later at or near where the tooth was taken Out. These may need another surgery to smooth or remove.



HENRIETTA FAMILY DENTAL
IMPLANT & DENTAL CARE

Patient's Name

Date

- ____ 10. The hole where the tooth had been might need more care, or small pieces of the tooth root might be left there to prevent damage to very important things like nerves or a sinus (a hollow place above your upper back teeth.)
- ____ 11. Upper back teeth are often close to the sinus and sometimes the tooth or a piece of root can get into the sinus and need more treatment. An opening may occur from the sinus into the mouth that may need more treatment.
- ____ 12. The roots of the lower teeth might be very close to the sensory nerve and, after the surgery, there might be pain or a numb feeling in the chin, lip, cheek, gums, teeth, or tongue. It is possible that you might lose your sense of taste. This might last for weeks or months and can be permanent.

INFORMATION FOR FEMALE PATIENTS

- ____ 13. I have told my doctor that I use birth control pills, I have been told that the birth control pills might not work if I take them and some other medicines (like antibiotics) and I could become pregnant. I agree to talk to my own doctor to start some other type of birth control while I am being treated and continue to use the other birth control until that doctor says I can stop.

ANESTHESIA

LOCAL ANESTHESIA: (Novocain, Lidocaine, etc.)

A shot is given to block pain in the area to be worked on.

NITROUS OXIDE WITH LOCAL ANESTHESIA: Nitrous Oxide (or laughing gas)

Helps to lessen uncomfortable sensations and offers some relaxation.

ORAL PREMEDICATION WITH LOCAL ANESTHESIA:

A pill is taken for relaxation prior to giving local anesthesia.

INTRAVENOUS SEDATION WITH LOCAL ANESTHESIA:

Makes you less aware of the procedure by making you calmer, sleepy, and less able to remember the procedure.

INTRAVENOUS GENERAL ANESTHESIA WITH LOCAL ANESTHESIA:

You will be completely asleep for the procedure.



HENRIETTA FAMILY DENTAL
IMPLANT & DENTAL CARE

CONSENT FOR ORAL SURGERY AND ANESTHESIA

Page 3 of 4

Patient's Name

Date

Whichever technique you chose, giving any medication involves certain risks. These include, but are not limited to:

1. Nausea and vomiting
2. An allergic reaction or unexpected reaction. If an allergic reaction is severe, it might cause more serious breathing or heart problems which may need treatment.
3. Confusion, or long period of sleepiness after surgery.
4. Heart or breathing responses which may lead to heart attack, stroke, or death.

Fortunately, these complications and side effects are not common. All forms of anesthesia are generally very safe, comfortable, and easy to deal with. **If you have any questions, PLEASE ASK.**

____ 14. The anesthetic I have chosen for my surgery is:

- Local Anesthesia
- Nitrous oxide/Oxygen Analgesia with local Anesthesia
- Oral Pre-medication with local Anesthesia
- Intravenous sedation with local Anesthesia
- General Anesthesia with local Anesthesia

____ 15. **ANESTHETIC RISKS** include, but are not limited to: Pain swelling, bruising, infection, Prolonged numbness and allergic reactions. There may be swelling (phlebitis) at the site where the needle goes into the arm that might cause discomfort for a long time and/or disability and might need special care. You might have nausea and vomiting from the IV sedation and/or General Anesthesia, but this does not happen often. Intravenous Sedation and/or General Anesthesia are serious medical

procedures and although considered safe, do carry the rare risks of heart irregularities, heart attack, stroke, brain damage, or even death.



HENRIETTA FAMILY DENTAL
IMPLANT & DENTAL CARE

CONSENT FOR ORAL SURGERY AND ANESTHESIA

Page 4 of 4

Patient's Name

Date

____ 16. YOUR OBLIGATIONS FOR IV SEDATION OR GENERAL ANESTHESIA ARE:

- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently able to care for yourself. **This may take up to 24 hours.**
- B. During recovery time you should not drive, operate complicated machinery or devices, or make important decisions.
- C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE THREATENING!
However, it is important to take any regular medications (high blood pressure, antibiotics, etc.) or any medications directed by us. With only a small sip of water.

CONSENT

I understand that my doctor can't promise that everything will be perfect. I certify that I speak, read, and write English, that I fully understand this consent form for surgery, and that all the blanks were filled in prior to my initialing and signing this form. All my questions have been answered to my satisfaction and I am willing to undergo the proposed surgery.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness's Signature

Date