ORAL SURGERY AND ANESTHESIA CONSENT

Patient name: ___________________________ Date ___________________________

Procedure Description: [ ] Extract upper and lower right and left wisdom teeth (teeth 1, 16, 17, and 32)

Extract teeth:  1  2  3  4  5  6  7  8  9  10  11  12  13  14  15  16  17  18  19  20  21  22  23  24  25  26  27  28  29  30  31  32

A B C D E F G H I J K L M N O P Q R S T

Anesthesia: [ ] Local anesthesia [ ] Intravenous sedation/general anesthesia

This is my consent for Anacapa Oral Surgery Dental Implant Center/Marwood Stout, D.D.S., Inc. to perform the procedure(s) and anesthesia as indicated above. If unforeseen circumstances require a change in procedure, I consent to the exercise of professional judgment, and performance of any other procedure deemed necessary or appropriate as an adjunct to the planned treatment. I also consent to seating and adjustment of removable prostheses, understanding there may be additional costs. Adjustment of removable prosthetic devices may result in discomfort or the need for replacement prosthesis.

I consent to tissue grafting as needed, which may involve my own bone or soft tissues, or human, animal, or synthetic tissues.

There are potential risks in any procedure and there may be complications to surgery, drugs, and anesthetics. These complications, mild or severe, may include, but are not limited to: postoperative pain, swelling, bruising, infection; delayed or poor healing which may necessitate prolonged recuperation, additional follow-up office visits or additional procedures; excessive or prolonged bleeding; injury to adjacent teeth or restorations; retention of a small piece of tooth or root when its removal would require extensive surgery; temporary or permanent altered sensation such as numbness, loss of taste sensation, tingling, burning or painful sensation of the lip, tongue, chin, gums, cheeks, bone, or teeth; sinus complications such as pain, congestion, drainage, or poor healing which results in an opening into the sinus, requiring additional surgery; dislodgment of root fragments into the sinus, requiring additional surgery for removal; injury and stiffness of the jaw, facial, or neck muscles, or restriction of mouth opening; changes in the occlusion (bite), injury to the temporomandibular joint (jaw joint), or worsening of any prior temporomandibular joint disorders, or fracture of the jaw. There is a remote chance of serious or life-threatening complications such as persistent severe pain or disability, need for hospitalization, cardiac arrest, heart attack, brain injury, or death.

Anesthetic risks include soreness or discoloration at an injection site or inflammation or infection along a vein, unfavorable or allergic reactions to medications; nausea or vomiting; or recollection of surgical events. Medications and anesthetics may cause drowsiness and lack of awareness or coordination. Vehicles or other hazardous devices cannot be operated for at least 24 hours. Any prescribed medication cannot be combined with alcoholic beverages or other depressant drugs. A responsible adult will stay with me until I am sufficiently recovered to care for myself.

I have not had anything to eat or drink, including water, for at least 8 hours prior to receiving anesthetic medications. To maximize treatment success, I understand I should refrain from the use of tobacco and nicotine products, follow the written and oral post-operative instructions, and to keep all prescribed post-operative appointments.

I understand I am responsible for payment of all professional fees, regardless of my insurance coverage. If signing for a minor, I certify my signature alone is sufficient to consent to treatment and that I am solely responsible for all treatment costs incurred by the minor patient. I have not been assured my insurance will actually pay for any or all treatments, even with a written preauthorization.

I have read and agree to the financial terms outlined in the PRESURGICAL INSTRUCTIONS. I have researched my treatment provider options, including those encouraged by my insurance carrier, and have chosen Anacapa Oral Surgery Dental Implant Center/ Marwood Stout, D.D.S., Inc. to render the above care. I decline treatment from another provider. I also give my consent for the taking of photographs, which may be used without compensation in scientific meetings or publications or marketing presentations.

I certify that I read and write English and I have read and I understand this consent. The nature of the planned procedure(s) has been fully explained to me, and all additional questions have been answered to my satisfaction. I have not initiated and signed a blank form. Although treatment goals and alternative treatments have been discussed, NO WARRANTY OR GUARANTEE HAS BEEN EXPRESSED OR IMPLIED as to any functional or esthetic result, outcome, or cure. Treatment fees will not be refunded in the event of complications or disappointing or failed treatment.

SIGNATURE (patient, or legal guardian) ___________________________ Date ___________________________ Witness ___________________________