

ORAL SURGERY AND ANESTHESIA CONSENT

Patient name:		Date	
Procedure Description: Extract upper and lower in the second se	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 A B C D E F G H I J K L			9 30 31 32
Anesthesia: ☐ Local anesthesia ☐ Intravenous sedatio	n/general anesthesia		
This is my consent for Anacapa Oral Surg- procedure(s) and anesthesia as indicated above. If und exercise of professional judgment, and performance of ar planned treatment. I also consent to seating and adjus- costs. Adjustment of removable prosthetic devices may re-	oreseen circumstance ny other procedure de stment of removable p	es require a change in procedure, I emed necessary or appropriate as ar prostheses, understanding there may	consent to the adjunct to the
I consent to tissue grafting as needed, which tissues.	may involve my own b	oone or soft tissues, or human, anim	al, or synthetic
There are potential risks in any procedure and complications, mild or severe, may include, but are not linealing which may necessitate prolonged recuperation, prolonged bleeding; injury to adjacent teeth or restorations extensive surgery; temporary or permanent altered sensa sensation of the lip, tongue, chin, gums, cheeks, bone, chealing which results in an opening into the sinus, requering additional surgery for removal; injury and stiffin changes in the occlusion (bite), injury to the temporoman disorders, or fracture of the jaw. There is a remote changain or disability, need for hospitalization, cardiac arrest, healing which results in any procedure and complete several part of the several par	mited to: postoperative additional follow-up of a small pation such as numbnessor teeth; sinus complicuiring additional surgess of the jaw, facial, dibular joint (jaw joint) nce of serious or life-tive additional or life-t	e pain, swelling, bruising, infection; doffice visits or additional procedures biece of tooth or root when its removals, loss of taste sensation, tingling, but cations such as pain, congestion, drawery; dislodgment of root fragments or neck muscles, or restriction of not worsening of any prior temporon threatening complications such as pe	lelayed or poor s; excessive or al would require rning or painful ainage, or poor into the sinus, nouth opening; nandibular joint
Anesthetic risks include soreness or discolunfavorable or allergic reactions to medications; nausea of may cause drowsiness and lack of awareness or coordinated hours. Any prescribed medication cannot be combined will stay with me until I am sufficiently recovered to care for	r vomiting; or recollect ation. Vehicles or othe d with alcoholic bevera	tion of surgical events. Medications a r hazardous devices cannot be opera	and anesthetics ated for at least
I have not had anything to eat or drink, including to maximize treatment success, I understand I should recoral post-operative instructions, and to keep all prescribed	frain from the use of to	obacco and nicotine products, follow	
I understand I am responsible for payment of a minor, I certify my signature alone is sufficient to conseincurred by the minor patient. I have not been assured in preauthorization. I have read and agree to the financial terms outlined in provider options, including those encouraged by my instance Center/ Marwood Stout, D.D.S., Inc. to render the above of the taking of photographs, which may be used with presentations.	ent to treatment and the present to treatment and the presure of the presure of the present and the present and the presume treatment are. I decline treatment are the present and the present are treatment are treatment.	hat I am solely responsible for all tally pay for any or all treatments, even in NSTRUCTIONS. I have researched ave chosen Anacapa Oral Surgery ent from another provider. I also give	reatment costs n with a written d my treatment Dental Implant my consent for
I certify that I read and write English and I procedure(s) has been fully explained to me, and all a initialed and signed a blank form. Although treatment gos GUARANTEE HAS BEEN EXPRESSED OR IMPLIED as not be refunded in the event of complications or disappoint	dditional questions ha als and alternative trea to any functional or e	ve been answered to my satisfaction atments have been discussed, NO W . sthetic result, outcome, or cure. Trea	on. I have not ARRANTY OR
SIGNATURE (patient, or legal guardian)	Date	Witness	