Informational Informed Consent

Oral Surgery and Dental Extractions

I UNDERSTAND that ORAL SURGERY and/or DENTAL EXTRACTIONS include possible inherent risks such as, but not limited to the following:

1. **Injury to the nerves:** This would include injuries causing numbness of the lips; the tongue; and tissues of the mouth; and/or cheeks or face. This numbness which could occur may be of a temporary nature, lasting a few days, a few weeks, a few months, or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.
2. **Bleeding, bruising, swelling:** Bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Bruises or hematomas may persist for some time.
3. **Dry Socket:** This occurs on occasion when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful.
4. **Sinus Involvement:** In some cases. The root tips of upper teeth lie in close apposition to the tissues of the sinuses. Occasionally during extraction or surgical procedures, this sinus membrane may be perforated. Should this occur, it might be necessary to have the sinus surgically repaired.
5. **Infection:** No matter how carefully surgical sterility is maintained, it is possible because of the existing non-sterile or infected oral environment, infections may occur post operatively. At times these may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon as possible should be received.
6. **Fractured Jaw, roots, bone fragments, or instruments:** Although extreme care will be used, the jaw, teeth roots, bone spicules, or instruments used in the extraction procedures any fracture or be fractures, requiring referral to a specialist. A decision may be made to leave a small piece of root, bone fragment or instrument in the jay when removal may require additional extensive surgery, which could cause more harm and add to the risk of complications.
7. **Injury to adjacent teeth or fillings:** This could occur at times no matter how carefully surgical and/or extraction procedures are performed.
8. **Bacterial endocarditis:** Because of the normal existence of bacteria in the oral cavity, the tissues of the heart, as a result of reasons know or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and bacterial endocarditis (an infection of the heart) could occur. It is my responsibility to inform the dentist of any heart problems known or suspected.
9. **Unusual reactions to medications given or prescribed**: Reactions, wither mild or sever, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Other methods of contraception must be utilized during the treatment period.
10. **It is my responsibility to seek attention should an undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given to me.**

Informed consent: I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and/or extraction of teeth and have received answers to my satisfaction. I have been given the option or seeking care from an oral and maxillofacial surgeon. I do voluntarily assume any and all possible risks, including the risk or substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fees (s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. David P. Gordon and/or his associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient Name (Please Print)	Signature of Patient, Or Legal Guardian	Date
Tooth #(s)	Witness	Date