South Cove Community Health Center
Dental Department
Oral Surgery Consent

Date: _____

Procedure to be perform: _____

_____

The oral surgery procedure to be performed has been explained to me and I understand what is to be done. This is my consent to the oral surgery indicated on the surgery record and to any other surgery deemed necessary or advisable in addition to the planned operation. I agree to the use of local anesthesia depending on the judgement of Dr. _____

I have been informed and understand that occasionally there are complications of the surgery, drugs, and anesthesia. The more common complications are pain, infection, swelling, bleeding, bruising and discoloration, temporary or permanent numbness and tingling of the lip, tongue, chin gums, cheek or teeth. It has been explained to me that pain and numbness and occasionally inflammation of the vein (thrombrophlebitis) may occur from an intravenous of intramuscular injection. The possibility of injury to or stiffness of the neck and facial muscles, changes in the occlusion or temperomandibular (jaw) joint have been explained. The doctors have discussed with me the possibility of injury to the adjacent teeth, restorations in other teeth, or injury to other tissues, referred pain to the ear, neck, head, nausea, vomiting, allergic reaction, bone/ mandibular fractures, and delayed healing. Sinus complications which may include a nasal fistula or opening into the sinus from the mouth may occur with removal of upper teeth.

Medications, drugs, anesthetics and prescriptive may cause drowsiness and lack of awareness and coordination which could be increased by use of alcohol or other drugs. Thus I have been advise not to operate any vehicle or hazardous devices until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care.

I acknowledge that receipt of and understand the post-operative instruction and have been given an appointment date to return. It has been explained to me and I understand that there is no warranty or guarantee as to any results and/or care. I understand I can ask for a full recital of any and all possible risks attendant to my care by just asking.

Patient: _____ _____ _____
Signature of Patient Date

Dentist: _____ _____
Signature Date

Verification checklist: Completed by: _____ (Staff signature)

Correct patient: Yes___ Correct extraction site: Yes___ Correct x-rays: Yes ___

Time out conducted : Yes___

Reviewed/ revised 09/07