South Cove Community Health Center
Dental Department
Oral Surgery Consent

Procedure to be perform:

_____

Blood Pressure: Pulse:

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 judgment 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 Name 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__

South Cove Community Health Center
華人醫務中心牙科
口腔外科手術同意書

要做的手術:

_____

Blood Pressure: Pulse:

口腔外科手術的程序已向本人解釋及本人亦明白此項手術的過程·本人同意在手術記錄中所建意的外科手術,並同意其他因需要而施行的手術·本人亦同意由 _____ 醫生所決定使用的局部麻醉藥·

本人已被解釋到有關外科手術,藥物,及麻醉可能帶來的併發症·一般的影響包括疼痛,發炎, 腫脹,流血,青腫及變色,嘴唇,舌頭,下巴齒齦,面頰,或牙齒有暫時或永久性的麻木及刺痛的感覺·本人亦已被解釋到有關由靜脈及肌肉注射可能帶來的影響,包括疼痛及麻痺及有時會引致的血管發炎.同時,本人亦明白到頭部及面部肌肉可能受損或變得僵硬,咬合及頸下頷關節的改變亦有被解釋·醫生們亦有對我解釋其他影響,包括對附近的牙齒的損傷,其他牙齒的修保,其他組織的損傷,對耳朵,頸部,或頭部可能引起的疼痛,惡心,嘔吐,過敏反應,骨折,或耽擱痊愈所需的時間·拔掉上排牙齒可能引致鼻竇炎,上頷竇穿通及其併發症,包括鼻廔或從口部到鼻竇裂開的情況·

醫藥,藥物,麻醉藥,及藥方可能引致昏昏欲睡的感覺及知覺和協調亦會因使用酒精或其他藥物而失控·因此本人已被勸告不要在二十四小時內或本人在診所內接受的麻醉藥,醫藥及藥物完全康復以前操作任何車輛及其他有危險性的工具·

本人已明白及收到有關在手術後的指示,並已有指定日期覆診·本人已被解釋及清楚明白到手術是沒有保證的·本人亦明白可以查詢任何與此手術有關的風險及問題,並可有員工與本人從新翻譯所有有關此手術的手續與問題.

顧客姓名: _____ **顧客簽名:** _____
日期: _____ **病历号:** _____ **生日:** _____

牙醫姓名(print): _____ 牙醫簽名**(Signature Of Dentist):** _____
日期: _____

Verification checklist: Completed by: _____(Staff signature)

Correct patient: Yes___ Correct extraction site: Yes___ Correct x-rays: Yes ___Time out conducted : Yes___