FORNI DENTAL

Max Forni DMD P.A.

INFORMED CONSENT FORM FOR ORAL AND MAXILLOFACIAL SURGERY AND ANESTHESIA

Dear Patient:

You have a right to be informed about your diagnosis and planned surgery so that you may make a decision whether to undergo a procedure after knowing the risks and hazards. The disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so we may give an informed consent to the procedure. Please be assured that we will do our best at all times to make healing as rapid and trouble-free as possible.

POSSIBLE COMPLICATIONS *(may be variable in occurrence):*
Please initial each paragraph after reading. If you have any questions, please ask your doctor before initialing.

_____ **ALL SURGERIES:**

1. Soreness, pain, swelling, bruising, and restricted mouth opening during healing sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exists.
2. Bleeding, usually controllable, but may be prolonged and required additional care.
3. Drug reactions or allergies.
4. Infection; possibly requiring additional care, including hospitalization and additional surgery.
5. Stretching or cracking at the corners of the mouth.

_____ **ALL TOOTH EXTRACTIONS:**

1. Dry socket (delayed healing) causing discomfort a few days after extraction requiring further care.
2. Damage to adjacent teeth or fillings.
3. Sharp ridges or bone splinters; may require additional surgery to smooth area.
4. Portions of tooth remaining - sometimes fine root tips break off and may be deliberately left in place to avoid damage to nearby vital structures such as nerves or the sinus cavity.
5. If tissue is removed or found on a tooth during an extraction it will NOT be sent for biopsy.

_____ **UPPER TEETH:**

1. SINUS INVOLVEMENT: Due to closeness of the roots of upper back teeth to the sinus or from a root teeth being displaced into the sinus, a possible sinus infection and/or sinus opening may result, which may require medication and/or later surgery to correct.

_____ **LOWER TEETH:**

2. NUMBNESS: Due to proximity of tooth roots (especially wisdom teeth) and other surgical sites to the nerves, it is possible to loose function of nerves following the removal of the tooth or surgery in the area. The lip, chin, teeth, gums, or tongue could thus feel numb (resembling local anesthetic injection). There may also be pain, loss of taste, and change in speech. This could remain for days, weeks, or possibly, permanently.
3. JAW FRACTURE: While quite rare, it is possible in difficult or deeply impacted teeth and usually requires additional treatment, including surgery and hospitalization.

_____ **ANESTHESIA:**

1. LOCAL ANESTHESIA: Certain possible risks exists that, although rare, could include pain, swelling, bruising, infection, nerve damage, and unexpected reactions which could result in heart attacks, stroke, brain damage, and/or death.
2. INTRAVENOUS OR GENERAL ANESTHESIA: Certain possible risk exists that, although uncommon, may include nausea, pain, swelling, inflammation, and/or bruising at the injection site.

Rare complications include nerve or blood vessel injury (phlebitis) in the arm or hand and allergic or unexpected drug reactions, pneumonia, heart attack, stroke, brain damage, and/or death.

ALTERNATIVE TREATMENT OPTIONS:_____

PATIENT NAME:_____

I hereby authorize Dr._____and staff to perform the following procedures:

_____

_

_____and to

administer an anesthetic. I understand the doctor may discover other or different conditions that may require additional or different procedures than those planned. I authorize him/her to perform such other procedures as he/she deems necessary in his/her professional judgment in order to complete my surgery.

I have discussed my past medical history with my doctor and disclosed all diseases and medications and drug use. I agree not to operate vehicles or hazardous machinery while taking prescription narcotic pain medications.

I have received written postoperative instructions regarding home care, including emergency after hour phone numbers.

I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following treatment, I agree to report them to the doctor or his/her designated agent as soon as possible.

I have read and discussed the preceding with the doctor and believe I have been given sufficient information to give my consent to the planned surgery. No warrantee or guarantee has been made as to the results or cure. I certify that I speak, read, and write English and have read and fully understand this consent form for surgery; or if do not, I have had someone translate so that I can understand the consent form. All blanks were filled in prior to my initials and signature.

_____

Patient's (or legal guardian's) signature Date

_____

Witness signature Date

_____

Doctor's signature Date