SURGICAL INFORMED CONSENT

I hereby give permission to _____ to perform the following procedure for myself or my child and such additional procedures are considered necessary on the basis of findings during the course of said procedure:

I consent for this to be done with local anesthesia only

The following alternative methods of treatment have been explained to be as being practical and possible, but I desire the treatment mentioned above:

I hereby certify that I fully understand this authorization for surgical treatment and the reasons why the above-named surgery is considered necessary. I have been given the opportunity to ask questions and have been given satisfactory answers.

I also understand that the administration of medications and performance of surgery carry certain common inherent risks, such as but not limited to:

1. Drug reactions and side-effects
2. Post-operative bleeding
3. Post-operative infection or bone inflammation
4. Necessary removal of bone during tooth extraction
5. Possible involvement of the sinus of the upper jaw during removal of upper back teeth, requiring possible surgery for repair at a future date
6. Possible involvement of the nerve within the lower jaw during removal of lower wisdom teeth, resulting in usually temporary, but possible permanent numbness
7. Bruising and/or vein inflammation at the site of the intravenous injections

I am aware that the practice of Dentistry and Oral Maxillofacial surgery is not an exact science, and I acknowledge that no guarantees have been made to me as a result of the procedures authorized above.

Name
(print)_____(Date)_____

Signature of Patient, Patient's Guardian _____

Witness's Signature _____