INFORMATIONAL USE ONLY

INFORMED CONSENT AND PERMISSION FORM

Before you give your permission for the removal of teeth, removal of impacted teeth (those that are "buried" or beneath the gums), or other dental treatment, and for the administration of certain anesthetics, you should understand there are certain associated risks.

The common risks are (but not limited to):

1. Drug reactions and side effects
2. Damage to adjacent teeth or fillings
3. Post-operative infection
4. Post-operative bleeding that may require treatment
5. Possibility of a small fragment of root being left in the jaw when its removal would require extensive surgery
6. Delayed healing (dry socket) necessitating frequent post-operative care
7. Possible involvement of the sinus during removal of upper molars which may require additional treatment surgical repair at a later date.
8. Possible involvement of the nerve within the lower jaw during the removal of lower molars resulting in temporary (but possible permanent) tingling or numbness of the lower lip, chin or tongue on the operated side.
9. Bruising and/or vein inflammation at the site of administration of intravenous medications which may require further treatment
10. Other: _____
    _____

I was given the option of different anesthetic techniques, and I consent for the following anesthetics to be used:

_____ Local anesthesia
_____ Local anesthesia with oral pre-medication
_____ Local anesthesia with intravenous sedation
_____ General anesthesia/hospital operating room

I hereby acknowledge I have completely read the foregoing; have discussed any questions or concerns which I may have regarding my proposed surgery/dental treatment, and have been given satisfactory answers. I am aware the practice of dentistry is not an exact science, and no guarantees can be provided.

_____ (please print)
Last First Initial

_____ _____
Date Signature of patient; patient's guardian or authorized representative

_____ _____
Date Witness signature