

INFORMATIONAL USE ONLY

CONSENT FOR ORAL SURGERY AND ANESTHESIA

Patient's Name: _____ Age: _____

I hereby consent to the oral surgery indicated on the exam form and/or any related therapeutic procedures that in the judgment of the doctors may be necessary for my well-being. The nature and purpose of the operation and the therapeutic alternatives have been explained to me. No guarantee has been made or implied as to the result or cure.

I also consent to the administration of general anaesthesia, or intravenous sedation, or local anesthesia and the taking of radiographs as indicated.

I have been informed of all probable complications of the oral surgery and the use of anesthetics and other drugs. These complications include swelling, discomfort, nausea, vomiting, infection, numbness of the lip, chin, tongue, or gum, bone fracture, drug reaction, inflammation of a vein, delayed healing, damage to teeth and restoration, bleeding and sinus involvement.

I also understand that I am not to operate a motor vehicle or hazardous device for a 24-hour period following surgery. Medication for pain, sleep or sedation may cause drowsiness; therefore, alcohol should be avoided when such medications are taken.

I acknowledge the receipt of and understand postoperative instructions and have been given an appointment to return.

Signed: _____

Relation (if minor): _____

Date: _____