NorthView Family Dental

Robert W. Leale, DDS
(509) 489-2538
5901 North Lidgerwood Street, Suite 225
Spokane, WA 99208
www.NorthviewFamilyDental.com

Oral Surgery/Extraction Consent Form

Patient Information and Consent Form

1. I authorize and consent to any other oral surgery considered necessary or advisable as a result of or in relation to the planned treatment.
2. I have been informed and I understand the purpose and the nature of the extraction procedure. I understand what is necessary to accomplish the removal of the tooth.
3. My doctor has carefully examined my mouth. Alternatives to this treatment have been explained (root canal therapy, crowns, periodontal surgery, etc.). I have tried or considered these methods, but I desire to have the tooth/root removed.
4. I authorize and request the use of any local anesthetics or drugs as may be considered advisable, depending on the judgment of the doctor(s) involved in my case.
5. I understand that the following situations may occur as a part of the oral surgery treatment:
   - Possible numbing (anesthesia) of one or both sides of the tongue (lingual nerves) and/or lower lip (inferior alveolar) nerves. When this happens, the feeling in these areas may not be normal for several weeks or months. In rare instances feeling may never return or a persistent discomfort may develop.
   - Possible involvement of the upper jaw-maxillary sinus that might involve further surgery, such as a sinus surgery and closure of an oral/sinus communication (openings between the mouth and sinuses).
   - Possible fracture of adjacent teeth or their restorations (fillings or crowns), which would require further treatment and corrections by a general dentist.
   - The decision may be made to leave a small piece of root in the jaw when its removal would require extensive surgery or treatment.
   - Possible fracture of the jaw that would require additional surgical procedures.
   - Possible swelling, bruising, pain, bleeding, nausea, vomiting, post-operative infection, delayed healing, infection, dry socket, phlebitis, unfavorable reaction to drugs and/or anesthetics.
   - Possible aspiration or swallowing of a foreign object such as a tooth or filling resulting in additional non-dental treatment.
   - Possible stiffness of the facial muscles and limited jaw opening, including pain, noises, clicking or locking of the jaw joints (TMJ), or change in the bite.
   - Stretching of the corners of the mouth resulting in cracking or bruising.
   - Bone spicules that may need removal at a different surgery.
6. I agree to the type of anesthesia, depending on the choice of the doctor. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for my care.
7. I understand that excessive smoking, alcohol, or sugar may affect healing and may result in complications related to healing. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.
8. I am <u>not</u> currently taking any bisphosphonates, i.e. IV treatments for cancer, Fosamax, Boniva, etc. _____ (Initials)

I have read the above statements, which have also been explained to me. I acknowledge that no warranty or guarantee of success has been or can be given in oral surgery procedures. I understand that it is very important that the doctor know of any medical problems I have and any medications I am taking now or have taken in the last few months. I agree to accept the services and treatment as offered by doctor(s) in my case, trusting that all will be done to fully benefit me and knowing that every precaution will be taken to prevent any complications.

_____
Signature of Doctor

_____
Signature of Patient

_____
Witness

If the patient is unable to sign or is a minor.
(Signature of parent or legal guardian)

_____
Date

_____
Relationship to Patient