

Informed Consent for Oral Surgery

The oral surgery procedure to be performed has been explained to me and I understand what is to be done. This is my consent to the oral surgery indicated on the surgery record and to any other surgery deemed necessary or advisable in addition to the planned operation. Risks to my health if the tooth/teeth are not removed include, but are not limited to:

1. Infection and/or pain
2. Periodontal (gum) disease
3. Loss of additional teeth
4. Cyst or tumor formation
5. Increased risk for complications if removal is completed at a later time

I have been informed and understand that occasionally there are complications of the surgery, drugs, and anesthesia. The more common complications are pain, infection, swelling, bleeding, bruising and discoloration, temporary or permanent numbness and tingling of the lip, tongue, chin, gums, cheek or teeth. It has been explained to me that pain and numbness and occasionally inflammation of the vein (thrombophlebitis) may occur from an intramuscular injection. The possibility of injury to or stiffness of the neck and facial muscles, changes in the occlusion, or temporomandibular joint has been explained. Dr. Kindt has discussed with me the possibility of injury to the adjacent teeth, restorations in other teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, vomiting, allergic reactions, bone fractures and delayed healing. Sinus complications which may include a nasal antral fistula or opening into the sinus from the mouth may occur with removal of upper teeth. The decision to leave a small piece of root when its removal would require extensive surgery and increased risk of complications will be at the doctor's discretion.

Medications, drugs, anesthetics and prescriptions may cause drowsiness, and lack of awareness and coordination which could be increased by the use of alcohol or other drugs; thus I have been advised not to operate any vehicle or hazardous devices or work while taking such medications and/or drugs or until fully recovered from the effects of the above. I understand and agree not to operate any vehicle or hazardous devices for at least 24 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care.

I acknowledge the receipt of and understand the post-operative instructions and have been given an appointment date to return. I agree to cooperate completely with Dr. Kindt and will follow post-operative instruction to the best of my ability for my own comfort and safety. It has been explained to me and I understand that there is no warranty or guarantee as to any result and/or cure. I understand I can ask for a full recital of any and all possible risks attendant to my care by just asking.

Patient, Parent or Guardian

Date

Timothy H. Kindt, DDS