

Consent for Minor Oral Surgery

Minor oral surgery is planned for you, and it is important that you understand the benefits and risks of such surgery. You have the right to be fully informed about your condition and the recommended treatment plan. The disclosures in this consent are not meant to alarm you, but rather to provide information you need in order to make a decision.

I hereby authorise Dr _____ and staff to carry out the procedure

_____ It has been explained to me both in writing and verbally that

- The surgical procedure planned has been explained to me and I understand the nature of the treatment.
- I have been informed of possible alternative forms of treatment (if any)
- My doctor has explained to me that there are certain potential risks and side effects of my surgery. They include but are not limited to :
 - a) Facial and jaw swelling after surgery, usually lasting several days
 - b) Bleeding, both during and after surgery
 - c) Allergic reaction to any of the medications given during or after surgery
 - d) Delayed healing of the bony segments, rarely requiring a second surgery and or bone graft to repair.
 - e) Loss of feeling, pain or tingling numbness in my chin, lips , tongue(including possible loss of taste) gums, or teeth that occurs in a significant number of patients (these symptoms may last for several days, weeks or months)
 - f) In upper jaw surgery, the sinus will be affected for several weeks
 - g) Post-operative infection which may cause loss of adjacent bone and or teeth and which may require additional treatment for a prolonged period of time.
 - h) Change in the position of the jaw joints (TMJ) that may cause post-operative discomfort, bite change and chewing difficulties. If TMJ symptoms existed before surgery, there may be no improvement and even some worsening of these symptoms after surgery.
 - i) I realise the importance of providing true and accurate information about my health, especially concerning possible pregnancy, allergies, medications and history of drug or alcohol use. If I misinform my doctor I understand the consequences may be life threatening or otherwise adversely affect the results of my surgery.

Information for female patients

I have informed my doctor about my use of birth controls pills. I have been advised that certain antibiotics and other medications may neutralise the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

Consent:

By signing this consent form, I acknowledge that I have read it completely and understood the procedure to be performed, the risks and the alternatives to surgery. I have had all my questions answered to my satisfaction . I was not under pressure to sign this form and have made a voluntary choice to proceed with surgery. I am fully aware that no guarantee or warranty can be made regarding the results of treatment. I certify that I speak, read and write English.

Patient's Name: _____

Patient's Signature _____ Date : _____

Surgeon's name _____

Surgeon's signature _____ Date: _____