Goehring Dental

Informed Consent for Surgical Procedures

I_____, voluntarily request Dr. _____and his/her assistants/associates to treat my condition described as: _____

_____

_____

The following procedure(s) have been recommended to me and I consent to and request their completion: _____

_____

I understand that if I choose not to complete the recommended procedures that my condition may worsen and result in pain, infection and the loss of teeth or bone.

Surgical complications may include:

1. Pain
2. Infection, which may require additional treatment
3. Decision to leave a small piece of root in the jawbone
4. Bruising
5. Bleeding
6. Limited mouth opening for a period of days or weeks
7. Opening of the maxillary sinus which may require additional treatment
8. Breakage of the jaw
9. Injury to a nerve or nerves in the face which may result in numbness or tingling in the lip, chin, gum, tongue, cheek, teeth on the operated side which may persist for weeks, months or in remote instances be permanent.
10. Jaw joint pain that may be temporary or permanent.
11. Other _____

Even though local anesthesia and sedation involves additional risks, to attempt to reduce pain and discomfort during the procedure, I consent to and request the administration of local anesthesia and _____ conscious sedation.

Risks associated with conscious sedation can include nausea, vomiting, irritation to veins, bruising, blood clot formation, sloughing of tissue, damage to vocal cords, allergic reaction, breathing problems, brain damage, cardiac arrest and death.

Conscious sedation does not always work successfully. Dr. Goehring/Dr. Badea cannot guarantee the results that may be obtained from the surgery or the sedation.

During this discussion, Dr. Goehring/Dr. Badea has answered my questions to my satisfaction and I ask to proceed with the plan noted above.

Patient:_____ Date:_____

Witness:_____ Date:_____

Dentist:_____ Date:_____