Goehring Dental
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Request and Authorization for Treatment or Surgery

I (we) voluntarily request Dr. Goehring/Badea, and/or any dentist(s) working with him or designated as their assistant(s), to perform the following treatment(s)/procedure(s)/surgery:

IV sedation, x-rays, exam, fillings and extractions

as previously explained to me, or other procedures deemed necessary or advisable to complete the planned operation.

_____ I understand that the purpose of the procedure/surgery is to treat and to possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present condition will probably worsen in time and the risks to my health include, but are not limited to the following: swelling, pain, infection, cyst formation, periodontal (gum) disease, dental decay malocclusion, pathologic fracture of the jaw, premature loss of teeth and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any. Dr. Goehring/Badea has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to the following:

_____1. Postoperative pain, discomfort and facial swelling that may necessitate several days of home recuperation.

_____2. Postoperative bleeding that may be prolonged.

_____3. Injury to adjacent teeth, crowns or fillings.

_____4. Postoperative infection requiring additional treatment.

_____5. Stretching of the corners of the mouth with resultant cracking and/or bruising.

_____6. Restricted mouth opening for several days or weeks.

_____7. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.

_____8. Breakage (fracture) of the jaw.

_____9. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months, or I some instances, permanently.

_____10. Opening of the sinus (a normal cavity situated above the upper teeth), requiring additional surgery.

_____11. Need for additional surgical treatment.

_____12. Bruising to the skin of the face, neck and intraoral soft tissues.

_____13. Temporary or permanent pain, dysfunction of the jaw joint requiring additional treatment or therapy.

_____14. Other_____

_____ Even though anesthesia (general and local) and sedation (oral, inhalation and intravenous) involves additional risks for the protection from pain and discomfort during the operation, I consent to and request the administration of anesthesia and/or sedation under the direction of Dr. Goehring/Badea and the use of such anesthesia and/or sedation agents that he may deem advisable.

_____Just as there are risks and hazards in continuing my present dental condition, uncorrected, there are also risks and hazards attendant to the performance of the surgical and/or diagnostic procedures planned for me. I realize that common side effects from the anesthesia or sedation may include nausea, vomiting, drowsiness and fatigue. Though not a complete list, other less common hazards may occur which include: allergic reactions, minor discomfort, and irritation to veins, blood clots, bruising of tissue, damage to vocal cords, tooth injury, paralysis, blindness and even death.

_____ Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or any other drugs. Thus, I have been advised not to work or operate any vehicle, automobile, hazardous device or participate in any activity requiring mental alertness while taking medications and/or drugs, or until fully recovered from effects of the same. I understand and agree not to operate any vehicle or hazardous device for at least 24 hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me home after my discharge and monitor my condition for a 24 hour period.

_____If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgement or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he may deem advisable.

_____ No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Because of the individual patient differences, there exists a risk of failure, relapse, selective retreatment or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful and that a worsening of my condition would occur sooner without the recommended treatment.

_____ I understand and agree that all tissue removed, including teeth, may be submitted to the pathologist for examination, and authorize him or Dr. Goehring/Badea to dispose of such tissue at their discretion.

_____I have had the opportunity to discuss my past medical and health history, including and serious problems and/or injuries.

_____I agree to cooperate completely with the recommendations of Dr. Goehring/Badea while under his care, realizing that any lack of same could result in a less-than-optimal result.

I certify that I have had an opportunity to read and fully understand the terms, words and explanations within the above consent to operation; that all blanks or statements requiring insertion or completion were filled in; and that inapplicable paragraphs, if any, were stricken before I signed. I also state that I read and write in English.

_____ _____

Patient/Parent/ Guardian Date

_____ _____

Witness Date

_____ _____

Doctor Date