Consent For Oral Surgery Using IV Sedation or General Anesthesia

1. _____I authorize Dr. _____ and staff to treat my condition. The procedure necessary has been explained to me, and I understand it to be:

   _____

   _____

2. _____I have been informed of possible alternate treatment options and understand that no treatment at all is also a choice.

3. _____The doctor has explained to me that there are risks in **ANY** procedure. We do not expect these to occur, but there is that possibility. In this instance such risks include, but are not limited to, the following:

   A. _____Opening of the sinus requiring additional surgery
   B. _____Injury to the nerve in the jaw resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue; this may persist for days, weeks, or in remote instances permanently.
   C. _____Postoperative discomfort and swelling
   D. _____Heavy bleeding that may be prolonged
   E. _____Injury to adjacent teeth and restorations
   F. _____Postoperative infection requiring additional treatment
   G. _____Stretching of the corners of the mouth
   H. _____Restricted mouth opening for several days
   I. _____Decision to leave a small piece of root in the jaw when it's removal would require extensive surgery
   J. _____Breakage of the jaw
   K. _____Soreness in injection site or along the vein may develop
   L. _____Cardiac or respiratory arrest or even death
   M. _____Other: _____

4. _____It has been explained to me that, during the course of the procedure(s) unforeseen conditions may necessitate an extension of the original procedures or different procedure(s) than those described above. I authorize and request the doctor perform such procedures as are necessary in the exercise of professional judgment.

5. _____I consent to the administration of anesthesia, including local, intravenous and/or general anesthesia with the exception of: _____ to which I said I was allergic.

6. _____Medications and anesthetics may cause drowsiness and lack of coordination, which can be increased by use of alcohol or other drugs; thus, I have been advised and agree not to operate any vehicle, automobile, or hazardous devices, or work, while taking such medications; or until fully recovered from the effects of same. I agree not to drive myself home after my discharge from surgery if I am put to sleep.

7. _____It has been explained to me, I understand, that a perfect result is not guaranteed or warranted.

8. _____I agree a d understand I am not to have and/or have not had anything to eat or drink for eight (8) hours before my surgery if I am going to be put to sleep.

9. _____I agree to cooperate with the recommendations of the doctor while under his/her care, realizing that lack of same could result in a less than optimum result.

10. _____I have read and fully understand this consent for surgery. **PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE SIGNING IT.**

_____	_____
Patient's signature Date	Parent or legal guardian (if under 18) Date
_____	_____
Witness (professional staff member) Date	Doctor Date