

Patient Name: _____

Date of Birth: _____

Stuart M. Nunnally, D.D.S., M.S.
Lane B. Freeman, D.D.S.
Candice H. Owens, D.D.S.
G. Rich Dorsey, D.D.S.
T. Ken Etheredge, D.D.S.

INFORMED CONSENT FOR ORAL SURGERY

I. RECOMMENDED TREATMENT

I hereby give consent to Dr. _____ to perform oral surgery procedure(s) for myself or my dependent as follows: _____

_____ and such additional procedure(s) as are considered necessary for my well being on the basis of findings during the course of said procedure(s). The nature and purpose of the procedure(s) have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with the procedure(s).

II. TREATMENT ALTERNATIVES

Alternative methods of treatment, including root canal treatment, have been explained to me, such as:

but I desire the treatment described above.

I also consent to the administration of local anesthesia during the performance of the recommended procedure(s).

III. RISKS AND COMPLICATIONS

I understand that there are risks and complications associated with the administration of medications, including anesthesia, and performance of the recommended surgery. These potential risks and complications, include, but are not limited to, the following:

1. Post-operatively I can expect some pain, swelling, discoloration of the face, and/or bleeding. Swelling may occur for several days after surgery.
2. Local anesthetic reactions may occur. Although rare, this could include numbness, swelling, pain, infection, abnormal reactions or allergy, and may adversely affect health.
3. Numbness or altered sensation may occur in the region of the surgery, gums, lips or tongue. This is usually a temporary condition, but in some cases may be permanent.
4. A dry socket (poor healing of the socket) may occur. A dry socket is painful and requires frequent treatment at the office.
5. Sinus communication (opening from tooth socket into the sinus cavity)
6. Root tips sometimes break off in the bone and may be left to avoid extensive surgery. With upper teeth, the root tips sometimes expose and are pushed into the maxillary sinus.
7. Infection is uncommon but may occur. Antibiotics may be needed postoperatively.
8. Fracture of the bone may occur.
9. Damage to adjacent teeth or restorations may occur. Temporomandibular joint dysfunction (the jaw joint not functioning well) may occur.
10. Any complications will be treated here, or you will be referred to the appropriate specialist if any additional treatment is needed. Treatment may consist of physical therapy, antibiotics, other drugs, or additional surgery.
11. Cavitation sites may heal at varying rates due to the fact that patients are unique and heal differently. There will be a charge for re-treating cavitation sites, and a six-month period must expire before re-treating.
12. I am aware that very often Drs. Nunnally, Freeman, Owens, Dorsey and Etheredge elect to use Platelet Rich Fibrin (PRF) in order to facilitate healing of surgical sites. If PRF is deemed necessary for optimal healing, my own venous blood flow will be used for the procedure.

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I am aware that the practice of dentistry is not an exact science and that the very nature of the treatment and my uniqueness as an individual require that no predictions can be made. I acknowledge that no guarantees have been made to me and that extracting the tooth/teeth may not have any effect on my health condition. I believe it is in my best interest to proceed with my chosen treatment, as opposed to any alternative which may exist. I agree to abide by the doctor's post-operative instructions and that my failure to properly care for my oral health may lead to further complications. I have had the opportunity to discuss with the doctor my overall health and medical history. I accept the risk of subsequent harms, if any, in hopes of obtaining the desired beneficial results of this treatment.

I am aware that no bone grafting material is used in any extraction sites or cavitation sites. Unless otherwise communicated with patient, only Platelet Rich Fibrin (PRF) will be placed. I understand that future restoration may require a bone graft and that procedure is not performed here.

I am aware that replacement of the tooth/or teeth extracted is recommended and I will be responsible for replacement expenses incurred.

The risks involved with anesthesia and the treatment itself have been fully explained to me and I do give my free and voluntary informed consent to the same.

Signed: _____ Date: _____
Patient/Parent/Guardian

Relationship (if patient a minor): _____

Witness (signature): _____