

INFORMATIONAL INFORMED CONSENT

ORAL SURGERY AND DENTAL EXTRACTIONS

I UNDERSTAND that ORAL SURGERY and/or DENTAL EXTRACTIONS include possible inherent risks such as, but not limited to the following:

- 1) **Injury to the nerves:** This would include injuries causing numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face. This numbness which could occur may be of temporary nature, lasting a few days, a few weeks, a few months, or could be permanent, and could be the result of surgical procedures or anesthetic administrations.
- 2) **Bleeding, bruising, swelling:** Bleeding may last several hours. If profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Bruises or hematomas may persist for some time.
- 3) **Dry socket:** This occurs on occasion when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful.
- 4) **Sinus involvement:** In some cases, the root tip of upper teeth lie in close apposition to the tissue of the sinuses. Occasionally during extraction or surgical procedures, this sinus membrane may be perforated. Should this occur, it may be necessary to have the sinus surgically repaired.
- 5) **Infection:** No matter how carefully surgical sterility is maintained, it is possible because of the existing non-sterile or infected oral environment, infections may occur postoperatively. At times these may be of serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon as possible should be received.
- 6) **Fractured jaw, roots, bone fragments, or instruments:** Although extreme care will be used, the jaw, teeth roots, bone, spicules, or instruments used in the extraction procedures may fracture or be fractured, requiring referral to a specialist. A decision may be made to leave a small piece of root, bone fragment, or instrument in the jaw when removal may require additional extensive surgery which could cause more harm and add to the risk of complications.
- 7) **Injury to adjacent teeth or fillings:** This could occur at times no matter how carefully surgical and/or extraction procedures are performed.
- 8) **Bacterial endocarditis:** Because of the normal existence of bacteria in the oral cavity, the tissue of the heart, as a result of reasons known or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and bacterial endocarditis (an infection of the heart) could occur. It is my responsibility to inform the dentist of any heart problems know or suspected.
- 9) **Unusual reactions to medications given or prescribed:** Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Other methods of contraception must be utilized during the treatment period.
- 10) **It is my responsibility to seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given to me.**

**INFORMED CONSENT:** I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and/or extraction of teeth and have received answers to my satisfaction. I have been given the option of seeking care from an oral and maxillofacial surgeon. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Brett T. Skinner and/or his associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

\_\_\_\_\_  
Patient's Name (please print)

\_\_\_\_\_  
Signature of patient, legal guardian  
or authorized representative

\_\_\_\_\_  
Date

Tooth # (s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Witness to signature

\_\_\_\_\_  
Date