

CHERRY HILLS DENTAL ASSOCIATES, P.C. - FAMILY DENTISTRY

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EVIDENCE OF INFORMED CONSENT TO SURGERY/ANESTHESIA/ANALGESIA

1. I hereby certify that I have authorized Dr.(s) _____
and/or such assistants as may be selected by him to perform the following procedure or operation:

2. I acknowledge that Dr. _____ has explained to me, in language that was easy to understand, the nature of my condition and symptoms and the manner in which the operation or procedures is expected to remedy this condition. He has made no guarantee or assurances to me concerning the results of the operation or procedure(s). I have had explained to me alternative methods of treatment, and agree to the above surgical approach. I also agree to the use of a local and/or ultralight general anesthetic, sedation, and analgesic, depending upon the judgment of the dentist(s) involved with my care.
3. I have been informed and understand that occasionally there are complications of the surgery, drugs and anesthesia. The more common complications are pain, infection, swelling, bleeding, bruising and discoloration, and temporary or permanent numbness and tingling of the lip, tongue, chin, gums, cheek or teeth. It has been explained to me that pain and numbness and occasionally inflammation of the vein (thrombophlebitis) may occur from the intravenous or an intramuscular injection. The possibility of injury to or stiffness of the neck and facial muscles and changes in the occlusion or temporomandibular joint have been explained. The doctors have discussed with me the possibility of injury to the adjacent teeth, restorations in other teeth, or other tissues, referred pain to the ear, neck, or head; nausea; vomiting; allergic reactions; bone fractures, and delayed healing. Sinus complications, which may include a nasal antral fistula or opening into the sinus from the mouth, may occur with removal of upper teeth. **THESE ARE NOT PROBABLE RESULTS — THEY ARE STATISTICAL POSSIBILITIES.**
4. I recognize that, during the course of the operation, additional or different procedures other than those described above may be necessary. I authorize such procedures as are, in my doctors professional judgment, desirable to my health, including attempts to remedy any conditions that are not known at the time the operation is begun.
5. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs, thus, I have been advised not to operate any vehicle or hazardous devices, or work, while taking such medications and/or drugs, or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four (24) hours, or until further recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care.
6. I acknowledge the receipt of pre-operative instructions, and understand that I should have nothing to eat or drink for at least eight hours prior to receiving general anesthetic.
7. I certify that I have read, have had explained to me, and fully understand the above consent to operation or other procedure(s), and that it is my intention to have the above carried out as stated. I verify that all blanks requiring insertion were completed, and any inapplicable paragraphs were stricken before I signed.

SIGNATURE

(Patient or Parent, if minor)

DATE

When the patient is a minor or incompetent to give consent, signature should be of person authorized to consent for the patient.

WITNESS

DATE