IMPACT

oral surgery

ORAL & MAXILLOFACIAL SURGERY DISCLOSURE & CONSENT

To the patient:

You have the right as the patient to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be done so that you may make the decision whether or not to undergo the procedure, knowing the risks involved. This disclosure is to help you be better informed, not to alarm you. It enables you to give or withhold consent for the recommended procedure. Please ask if there are any unanswered questions.

1. The nature and purpose of this operation ____

____

2. I have been informed of the possible risks and complications involved with the recommended surgery, anesthesia, and postoperative drugs to be used. Such complications include pain, bleeding, swelling, infection, dry socket and bruising. Despite the most delicate surgery, numbness of the lip, cheek, tongue, chin or teeth may occur. Injury to adjacent teeth, bone fracture, bone splinters or tooth fragments, sinus involvement, and delaying healing may occur. A slight chance of inflammation of the vein resulting in a knot in the arm or hand may occur from the IV. Allergic reaction to drugs or medication used could lead to a life-threatening crisis.

3. I understand that excessive smoking, alcohol or sugar may effect healing. I agree to follow my doctor's home care instructions. I agree to report to my doctor for any postoperative examinations if needed.

4. I agree on the type of anesthesia chosen by the doctor and myself and not to operate a motor vehicle or hazardous device for at least 24 hours or until fully recovered from the effect of the anesthesia and other medication given for care.

5. To my knowledge, I have given an accurate report of my physical and mental health history and reported any prior allergic or unusual reaction to drugs and/or foods. I have accurately reported any blood, skin or body diseases, abnormal bleeding or other conditions related to my health.

6. I consent to the recommended surgical/dental services or implant placement. I fully understand that during and following the contemplated procedure, surgery or treatment, conditions may become apparent, which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of the comprehensive treatment. I also approve of any modification in design, materials or care if it is felt to be in my best interest.

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Additional Implant Consent

7. I understand that if I have taken Fosomax (or any Bisphosphonate drug) any surgical procedure may result in a non-healing wound, requiring further surgery, pain or dysfunction.

8. It has been explained that in some instances implants fail and must be removed. I have been informed and understand that the practice of dentistry is not an exact science: no guarantees or assurances as to the outcome of results of treatment or surgery can be made. Alternatives to this treatment have been explained, but I desire an implant to help secure the replaced missing teeth.

9. I consent to photography, filming, recording and x-rays of the procedure to be performed for the advancement of implant dentistry, provided my identity is not revealed.

Doctor's signature ____

Signature of patient or parent / legal guardian ________________________________

Signature of witness ____________________ *Relationship to Patient* __________________

Date __________

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