ORAL SURGERY & SEDATION CONSENT FORM

Patient Name: _____ Date: _____

1. I, the undersigned, hereby consent to **Dr. Nick Seddon** or **Dr. Kyle Green** and his assistants performing the following procedure(s):_____

2. I acknowledge that the procedure(s), its implications and possible complications have been explained to me, along with the alternatives including not having any treatment. I also understand that during the course of any treatment, unforeseen circumstances may arise that make it advisable for an additional or alternate procedure to be performed, which I also consent to being performed

3. I understand that the procedure **will/will not** require minimal or moderate sedation, and I consent to the administration of this by the above-named practitioner administering the minimal or moderate sedation

4. I have been advised of possible complications of this procedure that are able to be reasonably anticipated, which are:

- □ Injury to a nerve, resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue to the operated side. This may persist for several weeks, months, or, in remote instances, permanently
- □ Post-operative infection, requiring additional treatment
- □ Opening of the sinus (a normal cavity situated above the upper teeth), requiring additional surgery
- □ Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint
- □ Injury to adjacent teeth and fillings
- □ In very rare circumstances, breakage of the jaw
- □ Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation
- □ Decision to leave a small piece of root in the jaw when its removal requires extensive surgery
- □ Stretching of the corners of the mouth with resultant cracking and bruising

5. I acknowledge receiving a copy of the pre- and post-operative instructions, which have been explained to me. I understand all the advice given to me by my dentist, and I understand that if I do not follow these instructions, there will be in increased chance of post-operative complications. After my discharge, I will notify my dentist if I experience any acute pain, heavy bleeding from the surgical site, respiratory problems, or any other post-operative problems.

6. I understand that no guarantee can be given of the results of surgery on the human body, but that the doctor and office staff will do their best to achieve excellent results.

7. All my questions concerning this procedure have been answered to my satisfaction.

Signature _____ Date _____
❑ Patient ❑ Parent ❑ Legally Authorized Representative

Witness _____ Date _____