EVERGREEN FAMILY DENTISTRY, P.C.

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INFORMATION AND CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY

I the undersigned, _____ , hereby authorize and request **Dr. Troy Fox of Evergreen Family Dentistry, P.C.** to perform the following oral and maxillofacial treatment upon me, or my dependent.

____ Extraction of impacted or unimpacted third molars (wisdom teeth)
____ Extraction of teeth
____ Removal of excess tissue and/or bone

And I consent to the performance of the above procedure(s), as well as to the performance of such additional/alternative procedures as in the judgment of Dr. Fox that may be necessary to restore and/or preserve my overall oral and dental health.

Risks and complications that may ultimately develop and/or immediately follow upon the above mentioned procedure(s) have been fully explained to me, including, but not limited to:

____ Numbness and tingling of the lower lip, tongue, gums, chin, cheek, bone and teeth which may be temporary or permanent, especially from the removal of lower (mandibular) teeth, or from surgery of the lower jaw. This may even result in indefinite burning pain (which may necessitate nerve repair).

____ Limitation of opening, stiffness of facial and/or neck muscles, change in the bite, or temporomandibular joint (jaw joint) difficulty, which may require physical therapy, or even surgery.

____ Discomfort and swelling, postoperative bleeding and discoloration, delayed healing and/or infection requiring prescriptions or additional treatment including surgery or bone grafts. Prolonged pain from bone exposure (dry socket) necessitating medicated dressings on a frequent basis.

____ Post-operative bleeding, hematoma, tooth sensitivity to hot or cold, gum shrinkage (possible exposing crown margins), or tooth looseness.

____ Possible bone fracture or spicules, or residual root fragments left when complete removal would require extensive surgery. Fractures that may require wiring or surgical treatment.

____ Sinus complications, oral-nasal or oral-antral fistulas and openings resulting from the removal of maxillary (upper) teeth or surgery on the maxilla possibly requiring additional treatment.

____ Injury to the adjacent teeth or restorations in or on adjacent teeth, resulting in the need for crowns, or extractions, or injury to other tissues not within the described surgical area, stretching of the corners of the mouth with resulting bruising or cracking.

I understand that any or all of the above complications may require the referral to an Oral Surgeon and additional fees. I agree to follow the written and verbal post-operative instructions given to me today and will keep all prescribed post-operative appointments.

The nature of the surgery and anesthesia has been <u>FULLY EXPLAINED TO ME</u> and no warranty or guarantee has been made as to results and/or cure. I understand I can ask for a full recital of all possible risks attendant to phases of my treatment by just asking, although I realize that some risks are so uncommon that they may not be apparent prior to surgery.

The fee for these services has been explained to me and is satisfactory. I have read and understand all of the above information, in English. I have been given information regarding available options, including no treatment, and consent to this procedure.

Signature: _____ Date: _____
(patient, or parent/guardian if minor)

Doctor: _____ Date: _____