El Paso
Quality Dentristry

Informed Consent
Oral Surgery / Extractions

I, _____ understand that the treatment being discussed if for the removal of tooth(teeth) and possible surrounding tissue and bone structures and it may entail certain risks. There is also the possibility of failure to achieve the results which may be desired or expected. I agree to assume those risks which may occur even though care and diligence will be exercised by my treating dentist in rendering this treatment. These risks include possible unsuccessful results and/or failure which are associated with, but not limited to the following:

1. Postoperative discomfort, swelling and/or infection that may necessitate several days of at home recuperation and/or further treatment. _____
2. Injury to adjacent teeth and fillings. _____
3. Stretching of the corner of the mouth with resultant cracking/bruising. _____
4. Restricted mouth opening for several days/weeks, secondary to stress of jaw joints (TMJ). _____
5. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery. _____
6. Facture of jaw _____
7. Dry socket _____
8. Allergic reactions (previously unknown) to any medications used in the procedure. _____
9. Cardiovascular or respiratory responses which may lead to heart attack, stroke, and/or death. _____
10. Opening into the sinus (a normal cavity situated above the upper teeth) requiring additional treatment. _____
11. Injury to nerves: Including possibility of injury to nerves of lips, jaws, teeth, tongue, other oral or facial tissues from any dental treatment. _____
12. Anesthesia: Anesthesia performed can be in form of a nerve block or local infiltrations. This is through the use of lidocaine, mepivicaine, marcaine, anticline. Side effects associated with the use of local anesthetic include: rapid heartbeat, fainting, hyperventilation, allergic reactions, toxic (overdose). The proper amount of anesthesia will be used in EPQD according to patient's weight.

contact@elpasoqualitydentistry.com
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Complications of anesthesia include other areas of face feeling numb, temporary or permanent paresthesia (lingering numbness), pain, bruising swelling and shocking to the nerve area. _____

Restorative options that include implants, bridges, and/or partials have been explained to me as further treatment that will be needed in order to replace the missing teeth being extracted. These options might require treatment from different specialists and will have an additional cost to treatment. _____

Sometimes in surgery unforeseen conditions may be discovered that might necessitate a change in approach or difference procedure from those explained above. I authorize all treating doctors to perform such procedures as are necessary and advisable in the exercise of this professional judgement. _____

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective retreatment or worsening of my present condition despite the care provided.

However, it is in the doctor's opinion that treatment would be helpful, and that a worsening of my conditions would occur sooner without the recommended treatment. _____

I understand that it is my responsibility to notify this office should any undue or unexpected problems occur or if I experience any problems in relation to the treatment rendered or the services performed.
_____

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INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purposes of composite fillings and have received answers to my satisfaction. 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 and/or any results from the treatment to be rendered to me. The fee(s) for these services have been explained to me and I accept them as satisfactory.

By signing this form, I am freely giving my consent to authorize Dr. _____ an/or all associates involved in rendering my services he/she seems necessary or advisable to treatment of my dental conditions, including the administration and/or prescribing of any anesthetic agents and/or medications.

_____	_____	_____
Patients Name (please print)	Doctors Name (please print	Date
_____	_____	
Signature of Patient, or Guardian	Witness Name (please print)	

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