



SOUTH CALGARY ORAL & MAXILLOFACIAL SURGERY

Consent Form for Oral Surgery

Patient Name _____ Date _____

I have been informed regarding the following oral surgical procedure(s);

I have reviewed the written and visual information provided to me.

The surgeon and/or staff have explained to me the proposed treatment. I understand there is the option of no treatment. I understand there are certain potential risks with the procedure.

These include:

1. A dry socket (bone irritation) may occur a few days after surgery. This condition may cause increased pain and can be managed by the surgeon.
2. Infection could happen after the surgery which may require antibiotics and/or surgical drainage.
3. Damage to the lower jaw nerves could occur after surgery and could result in temporary (6-12 months) or (rarely) permanent numbness to the lower lip, tongue and chin area.
4. If the upper teeth are close to your sinuses, their removal could cause a hole between the mouth and sinus. This may require additional surgery,
5. Stretching of the lips may cause irritation of the corners of the mouth.
6. Mild bleeding after the surgery is normal. There are occasional instances when increased bleeding may occur. Additional care by the surgeon may be necessary.
7. If the root tip of the extracted tooth breaks too close to a nerve or other vital structures, the surgeon may elect not to remove it.
8. Restricted mouth opening may occur for several days or weeks, with possible pain/clicking of jaw joint.
9. If your surgery is done with sedation or under a general anesthetic, the following risks may occur: Inflammation of the I.V. site, sore throat, hoarseness, lung problems and nose bleeds.
10. Hospitalization after the surgery may be necessary to control medical and surgical complications.
11. In the unlikely event of a medical crisis requiring life saving action, our team will undertake a full resuscitative effort through to and including the arrival of Calgary Emergency Medical Services. Please tell us **before treatment** should you not wish this effort to be undertaken on your behalf.

I understand this consent form. I give permission to the surgeon to do this procedure.

Patient (or Guardian) Signature: _____

Witness _____ Doctor _____