

CONSENT FOR ORAL SURGERY

I _____ hereby authorize Rebecca Taylor, D.D.S. and/or associates to perform the following procedure: _____.

Dr. Taylor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment.

Dr. Taylor as explained to me that there are certain potential risks in this treatment plan or procedure. These include:

1. Injury to a nerve resulting in numbness or tingling of the chin, lip cheek, gums and/or tongue on the operated side. This may persist for several weeks, months or, in remote instances, permanently.
2. Postoperative infection requiring additional treatment.
3. Opening of the sinus (a normal cavity situated the upper teeth) requiring additional surgery.
4. Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint.
5. Injury to adjacent teeth and fillings.
6. In rare circumstances, cardiac arrest or breakage of the jaw.
7. Postoperative discomfort, swelling, and bleeding the may necessitate several days of recuperation.
8. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
9. Stretching of the corners of the mouth with resultant cracking and bruising.
10. _____

Unforeseen conditions may arise during the procedure that require additional modifications to the procedure set forth above. I therefore authorize Dr. Taylor to perform such procedures when, in her professional judgment, they are necessary.

I understand that the medications, drugs, anesthetics and prescriptions taken for the procedure may cause drowsiness and lack because of awareness and coordination. I also understand that I should not consume alcohol or other drugs they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

Please don't hesitate to ask Dr. Taylor or team members if you have any questions.

Patient/Guardian Signature:

X

Rebecca Taylor DDS

O: 425-776-3352 F: 425-361-1485 E: lovemyteeth@greencitydental.com
A: 8405 196th St SW Edmonds, WA 98026 W: greencitydental.com