

CONSENT FORM

I am sure that you, the patient, would like to know more about the Oral Surgery Procedure you are about to undergo. This information is not meant to frighten you, but only to inform you about some of the risks of oral surgery.

When doing surgery in the mouth, injury and fracture to teeth, fillings, and jaw may occur in some instances. Roots of upper back teeth are in or near the sinus. If an opening occurs between the tooth socket and the sinus, or if a root enters the sinus following extraction, further surgery may be necessary. There are instances when a root tip may be knowingly left in place.

Following all surgery, pain, swelling, bruising and TMJ discomfort may normally be expected. Occasionally, trouble opening the jaws, bleeding, and infection may be a problem. Tingling or numbness of your lips, tongue, chin and gums and loss of taste can happen after removal of teeth because of their closeness to the nerves. This is usually temporary, but in rare occasions may be permanent.

The reason for and the nature of this operation has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages and disadvantages of each. I have been advised that although good results are expected, the possibility and nature of all possible complications cannot be accurately anticipated and that, therefore, there can be no guarantee as to the results of the surgery.

I authorize and direct Drs. Greiner, Visger Dental Associates to perform any other procedure that in their judgment is advisable for my well being, including but not limited to the administration of any anesthetic agent and the performance of all necessary laboratory, diagnostic, and surgical procedures, (including x-rays).

I hereby state that I have read and understand this consent, and that all questions about the procedures have been answered in a satisfactory manner.

Date

Patient or Guardian

Witness

Signature of Doctor