CONSENT FORM FOR SURGERY

I have been informed about and understand the purpose of this extraction or surgery. Alternatives to this treatment have been explained. I have been informed about the possible risks and complications involved with this surgery and anesthesia. These complications include but are not limited to

- Pain and immobility for a few days
- Swelling
- Infection and bruising
- Discoloration
- Numbness of the lip, tongue, chin, cheek, or teeth
- Injury to teeth and/or restorations
- Delayed healing
- Bone fractures, resorption (Can affect the future esthetics of front teeth)
- Sinusitis, or sinus perforation

The exact duration of these complications cannot be determinable and may not be reversible.

To the best of my knowledge, I have given accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollen dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition related to my heath.

I request and authorize dental services for myself. I fully understand that during and following the contemplated procedure, condition may become apparent which warrant, on the judgment of the dentist, additional or alternative treatment. This also includes referral to an oral surgeon if it is deemed necessary.

TOOTH NUMBER: ____________________

PATIENT NAME: ____________________

SIGNATURE: ____________________

DATE: ____________________