ORAL SURGERY ASSOCIATES AND DENTAL IMPLANT CENTERS

A Professional Association

Members of the American Association of Oral and Maxillofacial Surgeons

Members of the Georgia Dental Association

Statement of Consent for Oral Surgery Procedures

1. I, _____ hereby authorize Dr. Gordon L. Brady, Dr. Richard S. Singer, Dr. Robert Going, Jr. Dr. Brett C. Gray, Dr. Steven P. King, Dr. Fulton D. Lewis III, Dr. Steven D. Pollack, Dr. Mollie A. Winston, Dr. Scott E. Tate, Dr. Jeffrey M. Dyke, and any other agents or employees of Oral and Maxillofacial Surgery Associates, A Professional Association, and such assistants as may be selected by any of them, to treat my condition(s). The procedure(s) necessary to treat the conditions(s) have been explained to me and I understand the nature of the procedure to be:

_____

_____

_____

2. I have been informed of possible alternative methods of treatment (if any).

3. I have further understood that this is an elective procedure and other forms of treatment or no treatment at all are choices that I have, and that this treatment (in my doctor's opinion) will provide the optimum relationship between teeth, jaws, muscles, and the temporomandibular (jaw) joint that is possible at this time.

4. The doctor has explained to me that there are certain inherent and potential risks in ANY treatment plan or procedure. We do not expect these to occur, but there is that possibility. In this specific instance such operative risks include, but are not limited to, the following:

A. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

B. Injury to the nerve in the jaw resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side; this may persist for several days, weeks, months, years, or in remote instances permanently. The need for future microscopic surgery to fix nerves may be necessary.

C. Postoperative discomfort and swelling, that may necessitate several days of home recuperation.

D. Heavy bleeding that may be prolonged.

E. Injury to adjacent teeth and fillings.

F. Postoperative infection requiring additional treatment.

G. Stretching of the corners of the mouth with resultant cracking and bruising.

H. Restricted mouth opening for several days or weeks.

I. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.

J. Breakage of the jaw.

K. If intravenous medication is used, soreness at injection site or along the vein may develop as well as some discoloration of the injection site.

L. Cardiac arrest, respiratory arrest, or even death.

M. Other: _____

5. It has been explained to me that, during the course of the procedure(s) unforeseen conditions may be revealed that necessitate an extension of the original procedures or different procedure(s) than those set forth in paragraph 1 above. I, therefore, authorize and request that the person described in paragraph 1 above perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph 5 shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.

6. I consent to the administration of anesthesia, including local, intravenous and/or general anesthesia in connection with the procedure(s) referred to above, by any of the persons described in paragraph 1, and to the use of such anesthetics as may be deemed advisable with the exception of:_____to which I said I was allergic.

7. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness, and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile, or hazardous devices, or work, while taking such medications and/or drugs; or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four (24) hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery if I am put to sleep.

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

9. I agree and understand I am not to have and/or have not had anything to eat or drink for eight (8) hours before my surgery if I am going to be put to sleep.

10. I agree to cooperate completely with the recommendations of the doctor while I am under his care, realizing that any lack of the same could result in a less than optimum result and that failure to follow the doctors suggestions and directions could be even life threatening.

11. I certify that I read and write English and have read and fully understood this consent for surgery. PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE SIGNING IT.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

{X_____} Date:
Patient/Parent or Legal Guardian (if under 18)

{X_____} Date:
Witness (Professional Staff Member)