INFORMED CONSENT AND PERMISSION FORM

Before you give your permission for the removal of teeth, removal of impacted teeth (those that are "buried" or beneath the gums) or other dental treatment, or for the administration of certain anesthetics, you should understand that there are certain associated risks.

Common risks include but are not limited to:

1 Drug reactions and side effects

2 Damage to adjacent teeth or fillings

3 Postoperative infection

4 Postoperative bleeding that may require treatment

5 Possibility of a small fragment of root being left in the jaw and its removal requiring extensive surgery

6 Delayed healing (dry socket) necessitating frequent postoperative care

7 Possible involvement of the sinus during removal of upper molars, which may require additional treatment or surgical repair at a later date

8 Possible involvement of the nerve during the removal of lower molars resulting in temporary or possible permanent tingling or numbness of the lower lip, chin or tongue on the operated side

9 Bruising and/or vein inflammation at the site of administration of intravenous medications, which may require further treatment

10 Other: _____

_____

I was given the option of different anesthetic techniques, and I consent for the following anesthetics to be used:

_____ Local anesthesia

_____ Local anesthesia with intravenous sedation

_____ Local anesthesia with oral premedication

_____ General anesthesia/hospital operating room

I hereby acknowledge I have completely read the foregoing, have discussed any questions or concerns that I may have regarding my proposed surgery/dental treatment, and have been given satisfactory answers. I am aware that the practice of dentistry is an inexact science and that no guarantees can be provided and none have been made to me.

_____

Last First Initial (please print)

_____ _____

Patient, guardian or authorized representative signature Date

_____ _____

Witness to signature Date

INFORMED CONSENT AND PERMISSION FORM