Informed Consent for Dental Surgery

Patient Name/DOB:_____

This is my consent for Dr. Burkardt (general dentist) or any other dentist/surgeon working with him to perform the following surgery/treatment procedure:

_____

I also give my permission for any other procedure which may become necessary to complete the planned procedure.
_____ (initial)
I have been informed of the possible alternative methods of treatment which is/are: no treatment, treatment with local anesthetic only, and additional options listed here if applicable: _____.
_____ (initial)
The doctor has explained to me that certain risks and complications exist for any surgery or procedure. I was given the opportunity to ask questions and am satisfied with my knowledge of the procedure and wish to proceed. In this instance, risks include but are not limited to all the following unless otherwise indicated:

1. Postoperative pain and swelling which may require several days of recuperation.
2. Bleeding which may occur for up to 24 hours and possible bruising.
3. Injury to adjacent teeth or dental restorations.
4. Post-operative infection requiring additional treatment or hospitalization in rare cases.
5. Stretching or cracking of the corner of the mouth or lips.
6. Difficulty opening the mouth for several days following the procedure.
7. Decision to leave a small piece of tooth root in the jaw when its removal would require extensive further surgery or represents a risk of injury if removed.
8. Fracture of the jaw.
9. Injury to the nerves in the area resulting in numbness of the lips, chin, gums, cheek, teeth and/or tongue. This numbness is likely to persist for several weeks, months, or in rare instances may be permanent.
10. Opening from the sinus to the mouth which might require additional surgery.
11. Temporomandibular joint pain or clicking.
12. I understand that certain risks, which could involve serious bodily injury, are inherent in any procedure where a general anesthetic or sedation is used. These include, but are not limited to: bruising, numbness, or infection at the injection site, cardiac arrest and in extremely unlikely circumstances, death.
13. Other_____

I have read and understand the potential risks/complications of the procedure and have had my questions or concerns addressed to my satisfaction.
_____ (initial)
IV SEDATION: I have not had anything to eat or drink for a minimum of eight (8) hours prior to my scheduled procedure.
_____ (initial)

I consent to the administration of local anesthetic and sedation as deemed necessary by Dr. Burkardt or his associate to accomplish the proposed procedure. I understand that these medications and prescriptions may cause drowsiness, affect coordination and this can be increased by alcohol or other drugs. I have been advised not to operate any vehicle or hazardous device or work while taking medication until I recover fully from their effects. I agree to have a responsible adult drive/accompany me home after my procedure if sedated.

_____ (initial)

I understand that protective stabilization (wrist cuffs or an assistant holding my hands or feet etc…) may be employed to keep me from disrupting the working field and causing injury to myself, the doctor, or his team.

_____ (initial)

No guarantee, warranty or assurance has been given to me that the treatment will be curative and/or successful to my complete satisfaction. There is a risk of failure, relapse, need for continued treatment or worsening of the present condition despite the care provided.

_____ (initial)

I have disclosed my past medical history and have/will answer all such questions fully and accurately concerning disease, illness, or injury as well as allergies to drugs and possibility of pregnancy (or breast feeding) if appropriate.

_____ (initial)

I choose to be seen in this office, by this dentist, for this surgery as opposed to a hospital setting. I am also aware the dentist will follow up via phone and possibly in person, but my primary face to face follow up may be with one of my other primary providers. For certain unusual (but possible) complications, I may need follow-up in another office later, by a periodontist, oral maxillofacial surgeon, physician etc…

_____ (initial)

I certify that this procedure, treatment, or surgery has been explained to me along with the possibility of risks and complications. I have had the opportunity to ask questions about this procedure and these questions have been answered to my satisfaction. If I have more questions, I will ask the doctor promptly. I also certify that I have read and understand this consent for the procedure, treatment, or surgery. My signature or the signature of the parent/legal guardian constitutes consent to proceed with the proposed procedure by Dr. Burkardt (general dentist) and any other associate Dr.(s) working with him.

_____

Signature of patient or legal guardian (if patient is a minor) DATE

_____

Signature of Doctor DATE

_____

Signature of witness if deemed appropriate DATE