DENTAL SURGEONS & IMPLANT CENTERS
OF FALL RIVER AND DARTMOUTH

CONSENT FOR DIAGNOSIS AND SURGICAL PROCEDURES

_____

Patient's Name Date

This consent form is intended to make you better informed so that you may give or withhold your consent to the proposed diagnostic and therapeutic procedure(s).

As I am presenting myself / child to the office of Dental Surgeons & Implant Centers I agree to diagnostic procedures (including x-rays) that are deemed necessary for the proper determination of my condition.

Dental Surgeons & Implant Centers has explained to me the following conditions exist in my case:

Impacted/Malfunctional/DecayedTeeth#'s_____

_____#1,16,17,32 (4 wisdom teeth)_____

and the recommended treatment will be Extraction / Removal of the Teeth #'s_____

_____#1,16,17,32 (4 wisdom teeth)_____

under Local / Nitrous Oxide / IV General/Sedation Anesthesia_____

_____

And that this will be performed by Dental Surgeons & Implant Centers and others under their discretion utilizing, local anesthesia, nitrous oxide anesthesia, and intravenous sedation with local anesthesia.

Alternative treatments would be: No Surgery_____

BENEFITS / RISKS OF PROPOSED PROCEDURE(S):

I am aware that the practice of anesthesia and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the result of either the anesthesia or surgery. Just as there may be benefits to the anesthesia and procedure(s) proposed, I understand that both of these procedures may involve risks. These risks may include but are not limited to the following:

1. Allergic or adverse reactions to the medication or materials.
2. Post operative swelling, pain, bleeding and / or bruising.
3. Delayed recovery and / or difficulty opening the mouth.
4. Infections requiring extended treatment.
5. Initiation or exacerbations of TMJ (jaw joint) problems requiring treatment.
6. Openings into the sinus possibly requiring further treatment.
7. Recurrence of growths after removal,
8. Decision to leave a small piece of tooth or filling in the jaw when removal would require extensive surgery.
9. Soft tissue may be cut which might require stitches.
10. Teeth may be damaged requiring fillings, crown, and root canal treatment or even extraction.

11. Nerves may be injured which would lead to numbness or pain of the lip, tongue, gums, teeth or chin which in most cases is temporary but may in rare cases be permanent.
12. Bone fragments or bone spurs may occur during healing, requiring removal.
13. Fracture of the jaw in rare cases.
14. Pain, bruising and loss of tissue in the arm at the site of injection when intravenous drugs are used.
15. Unforeseen life threatening events due to either anesthesia or surgery.
16. Injury to the fetus in cases of pregnancy.

ACKNOWLEDGEMENTS:

I have provided an accurate and complete medical and personal history which included all infectious diseases (Hepatitis, Venereal Disease, AIDS, and TB) and all medications taken (including Birth Control Pills). It has been explained to me and I understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control of one complete cycle of birth control pills, after the course of antibiotics or other medications is completed.

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 vehicles, automobile or hazardous devises, or to return to work, while taking such medications, and / or drugs; or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device for 24 hours after my release from surgery or until further recovered from the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. If sedative drugs have been given to me at the time of surgery, 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.

Anesthesia or surgery during pregnancy especially during The First Trimester of pregnancy can possibly have disastrous effects on the fetus. We are relying on you to tell us whether you are pregnant at the time of surgery. **Do you wish to consult your physician to rule out pregnancy before oral surgery?**

_____ Yes _____ No

If you believe you are pregnant you may want to postpone your treatment.

I have considered that available alternative treatments offered to me including no treatment at all. I understand what has been discussed with me as well as the contents of the consent forms and have been given the opportunity to ask questions and have received satisfactory answers prior to signing this form and voluntarily give my authorization and consent to the performance of the procedure(s) described above.

_____

Patient's (or Legal Guardian's) Signature Date

_____

Doctors Signature Date

_____

Witness' Signature Date