tuscany dental centre

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Oral Surgery Consent Form
Dr Cam Brauer DMD &/or Dr Scott Townsend DDS

This is my consent for Dr. ________________________ and any associates to perform the following

Procedure ____________________________________for Name: _________________________.

The doctor and / or staff have explained to me the proposed treatment and the anticipated results of the treatment. I understand this is my choice to proceed with treatment as there is the option of doing this work or doing nothing at all.

The doctor has ***explained*** to me that there are certain potential risks in the treatment plan or procedure. These include:

- Injury to Nerve resulting in numbness or tingling of the chin, lips, cheek, gums and or tongue to the side being treated. This may persist for several weeks, months, or in remote instances, permanently. ___________(initial)
- Post operative infection requiring additional treatment.
- Sinus involvement – the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced or the tooth itself can dislodge into the sinus or an opening may occur into the mouth, which may require additional care.
- Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular joint.
- Injury to adjacent teeth and/or fillings.
- In rare circumstances, medical situation requiring medical personnel and or ambulance can occur.
- Post operative discomfort, swelling, and bleeding that may necessitate several days of recuperation
- Decision to leave a small piece of root in the jaw when it's removal requires extensive surgery or complication.
- Stretching of the corners of the mouth with resultant cracking and bruising
- For patients who receive IV Sedation it is required that they **do not consume food 6 hours prior** to treatment or **beverages 2 hours prior** to treatment. You must rest in an upright position following surgery.

To my knowledge, I have given an accurate report of my health history.

Unforeseen conditions may arise during the procedure that requires a different procedure than as set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary.

I understand that the medications, drugs, anesthetic, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can cause additional side effects. I have been advised not to work and not to operate any vehicle, automobile or hazardous devices while taking such medications and until fully recovered from their effects.

I have also been advised not to smoke for two weeks after the surgery __________

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

____________________________________ ______________________

Patient Signature / Guardian (if under 18 years of age) Date
(Print name then sign please)

____________________________________ ______________________

Doctor Signature Date