[Place this form on office letterhead]

INFORMED CONSENT FOR ORAL SURGERY AND ANAESTHESIA

1. This is my consent for Dr. _____ and/or any dental surgeon and dental assistants who are working with him or her to perform the following treatment/procedure/surgery: _____
   _____
   _____
   _____
   as previously explained to me, or the procedures deemed necessary or advisable as necessary to complete the planned operation.

2. I understand the nature of the procedure/surgery and that the purpose of the procedure/surgery is to treat my diseased oral/maxillofacial tissues and/or extract teeth. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition may or may not worsen in time, and the risks to my health may include, but are not limited to, the following: swelling, pain, infection, cyst/tumour formation, periodontal (gum) disease, dental caries, malocclusion, pathologic fracture of jaw, premature loss of teeth, and /or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

3. The dental surgeon has explained to me that there are certain normal sequelae (after-effects) inherent in any oral surgery treatment plan or procedure and that in this specific instance such sequelae may include one, none, or all of the following:
   - Post-operative discomfort and swelling that may necessitate several days of home recuperation.
   - Post-operative bleeding that may be prolonged and require treatment.
   - Post-operative infection requiring additional treatment.
   - Restricted mouth opening for several days or weeks.
   - Bruising of skin and gums.
   - Delayed healing with accompanying pain (dry socket).

4. There is also the remote risk of complications with this procedure/surgery. They include but are not limited to:
   - Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months, or in rare instances, permanently.
   - Injury to adjacent teeth, fillings, bone and gums.
   - Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
   - Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
   - Other: _____
     _____
     _____
     _____
     _____

5. Depending on their strength, certain medications, drugs, anaesthetics 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 affects of same. If sedation is given 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 affects of the anaesthetic medication and drugs that may have been given to me in the office. 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.

6. I agree to cooperate with the recommendations of the dental surgeon while I am under his or her care, realizing that any lack of same could result in a less than optimum result, and I agree to attend post-operative assessment appointments when necessary.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS CONTAINED WITHIN THE ABOVE CONSENT AND THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE.

Patient Name (please print)	*Signature of Patient (or Guardian)*
Name of Witness (please print)	*Signature of Witness*
Date	