Surgical/Anesthesia Consent

Name:_____ Date:_____

I have been informed regarding the following oral surgical procedure(s):

_____

_____

_____

I have reviewed the information provided to me**.** Dr Bureau and/or his staff have explained to me the proposed treatment.

I understand there are certain potential risks with the procedures.

1- Dry socket (bone irritation) may occur few days after the surgery. This condition may cause pain and can be managed by pain medication or topical analgesic

2- Infection after surgery which may require antibiotics and/or surgical drainage. In rare instances admission to hospital for management could be required

3- Damage to the lower jaw nerves could occur and result in temporary (6-12 months) or (rarely) permanent numbness of the lower lip, chin and sometimes tongue area

4- If the upper teeth are close to the sinuses, their removal could cause a hole between the mouth and the sinus. This may require another surgery to close it

5- Stretching of the lips may cause irritation of the corners of the mouth

6- Mild bleeding after surgery is expected. Sometimes an increase amount of bleeding can occur requiring extra care. Hospitalization is rarely needed

7- If the root tip of the extracted tooth breaks too close to a nerve or other vital structures, the surgeon may elect not to remove it

8- Restricted mouth opening may occur for several days or weeks, with possible pain/clicking of the jaw joints. If this persists, jaw exercises may be required

9- Adjacent fillings, crowns /bridges or weakened teeth can be damaged during the surgical process and may require further dental treatment

10- If your surgery is done under sedation or under a general anesthetic (asleep), the following risks may occur: Inflammation of the intravenous site, sore throat, hoarseness, lung problems (infection), and nose bleeds

11- Hospitalization after the surgery may be necessary to control medical and surgical complications

12- In the unlikely event of a medical crisis requiring life saving actions, our team will undertake full resuscitative efforts until the arrival of emergency medical services. Please tell us should you not wish these efforts undertaken on your behalf.

I understand this consent form. I give Dr Steve Bureau permission to do the procedure(s) described above

Patient (legal guardian) signature:_____

Witness:_____ Surgeon:_____