SURGERYCONSENT 1/2
informed consent Nina Kumar, DDS

Patient Name: _____

Date: ____/____/_____

I request/authorize that Dr. _____
perform the following procedure:

_____

_____

The doctor has recommended this treatment because of :

☐ Pain ☐ infection ☐ Periodontal/"Gum" Disease
☐ Decay ☐ Fracture ☐ Non-Restorable
☐ Other:_____

_____

The doctor and/or staff have explained to me the proposed treatment and the anticipated results of such treatment. The doctor has explained to me that there are certain certain inherent and potential **risks** associated with any type of surgical procedure. These include, but are not limited to:

a. Injury to a nerve resulting in numbness or tingling of the chin, lips, cheek, gums, and or tongue to the operated side. This may persist for several weeks, months, or in remote instances, permanently.
b. Postoperative infection, which may require additional treatment.
c. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery
d. Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint.
e. Injury to adjacent teeth and fillings.
In rare circumstances, cardiac arrest or breakage of the jaw.
g. Postoperative discomfort
h. Decision to leave a small piece of root in the jaw when its removal requires extensive surgery.
j. Stretching of the corners of the mouth with resultant cracking and bruising.
k. Other: _____

_____

Additionally, I have been informed of the Necessary Follow-up Care and Self-Care. It is important for me to continue routine dental care.
I have told the doctor about any pertinent medical conditions I have, allergies (especially to medications or sulfites (many local anesthetics have sulfite preservatives)) or medications I am taking, including over the counter medications such as aspirin.
I may need to come back in for several post-op appointments following my surgery so that healing may be monitored and so Dr. Kumar & her staff can evaluate and report on the outcome of surgery.
Smoking, excessive alcohol intake or inadequate oral hygiene may adversely affect gum healing and may limit the successful outcome of my surgery. I am aware that it is important to:

1. Abide by the specific prescriptions and instructions given.
2. See Dr Kumar & her staff for post-operative check-ups as needed.
3. Stop smoking (particularly the first 2 weeks after my procedure)
4. Perform excellent oral hygiene as instructed

While in most cases dental surgery is successful, **NO GUARENTEE** has been given to me that the proposed dental surgery will be successful. Due to individual patient differences no one can predict certainty of success. There is a remote possibility of a worsening of my present condition, including the loss of teeth, despite the best of care.

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

INITIAL: _____

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling my doctor of any pertinent medical conditions and prescription and non-prescription medications I am taking. I have had an opportunity to ask questions. I consent to the performance of the surgery as presented to me and as described above. I also consent the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Kumar & her associates. I have read and understand this document before I signed it.

_____
Printed Name of Patient

Date: ____/____/_____

_____
Printed Name of Witness

Date: ____/____/_____

_____
Signature of Patient, Parent, or Guardian

_____
Signature of Witness