PROFESSIONAL PROTECTOR PLAN® FOR DENTISTS | PPP

Consent for Oral Surgery

A. RECOMMENDED TREATMENT

I give permission to Dr. _____to perform the following treatment as well as any additional procedures considered necessary on the basis of findings during the actual surgery. This permission is for myself (or minor child) named below. I fully understand this consent for surgery and the reasons why the recommended treatment is necessary. I have been given the opportunity to ask questions regarding the recommended treatment and have been given satisfactory answers. I understand that no guarantee regarding the treatment has been made or implied.

TREATMENT: _____

B. TREATMENT ALTERNATIVES AND NO TREATMENT CONSEQUENCES

I elected the treatment listed above even though the following alternatives have been explained to me as being both practical and possible.

TREATMENT ALTERNATIVES: _____

C. ANESTHESIA/MEDICATIONS

I also authorize the recommended treatment to be performed with the following anesthetics and/or medications:

_____Local anesthesia only

_____Local anesthesia with nitrous oxide and oxygen

_____ Local anesthesia and sedation

D. RISKS AND CONSEQUENCES

I understand that there are risks associated with the administration of medications and performance of the recommended surgery such as the items check below:

_____ Drug reactions and side effects

_____ Post- operative bleeding and pain

_____ Necessary removal of bone during tooth extraction

_____Post-operative infection or bone inflammation

_____ Possible damage to the sinus when upper back teeth are removed which may require surgical repair at a future date

PROFESSIONAL PROTECTOR PLAN® FOR DENTISTS | PPP

D. RISKS AND CONSEQUENCES (continued)

I understand that there are risks associated with the administration of medications and performance of the recommended surgery such as the items check below:

_____ Possible nerve damage when lower wisdom teeth are removed which can result in either temporary or permanent tingling or numbness in the lower lip

_____Fracture of the mandible

_____ Jaw joint (TMJ) pain, malfunction and/or difficulty in opening mouth due to muscle spasms, following removal of lower teeth

_____ _____

Date Patient or Patient's Guardian

_____ _____

Date Witness

_____ _____

Date Doctor