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
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