Patient's Name_____

ORAL SURGERY CONSENT FORM

SWELLING, BRUISING AND PAIN
These can occur with any surgery and vary between patients and from one surgery to another. You may require several days at home for recovery. You may also have stretching of the corners of the mouth that may cause bruising and may heal slowly.

TRISMUS
This is the limited opening of the jaws due to inflammation in the muscles. This is more common with impacted tooth removal but is possible with almost any surgery. There is a higher likelihood if TMJ (see below) problem already exists.

INFECTION
This is possible with any surgical procedure and may require further surgery and/or medications if it does occur.

BLEEDING
Although significant bleeding can occur during or after surgery, it is not common. Some bleeding is, however, expected with most surgeries and is normally controlled by following the post-op instruction sheet. Prolonged or heavy bleeding may require additional treatment.

TMJ DYSFUNCTION
This means the jaw joint (Temporomandibular Joint) may not function properly and, although rare, may require treatment ranging from use of hot/cold compress and rest to further surgery.

LOCAL ANESTHESIA
Certain possible risks exist that, although uncommon or rare, could include pain, swelling, bruising, infection, nerve damage, idiosyncratic or allergic reactions.

ALLERGIC REACTION
Allergic reaction, such as itching, rash, swelling, difficulty in breathing, is possible to any medication used it treatment.

DRY SOCKET
This is significant pain in the jaw and ear due to the loss of the blood clot and most commonly occurs after the removal of lower wisdom teeth, but it is possible with any extractions. Incidence increases with poor oral hygiene, smoking, birth control pill use. This may require additional office visits to treat.

DAMAGE TO OTHER TEETH AND FILLINGS
Due to the close proximity of teeth, it is possible to damage other teeth and/or fillings when a tooth is removed

SHARP RIDGES AND BONE SPLINTERS
Occasionally, after an extraction, the edge of the socket will be sharp or a bone splinter will come out through the gum. This may require another surgery to smooth or remove the bone splinter.

INCOMPLETE REMOVAL OF TOOTH FRAGMENTS
There are times when the dentist may decide to leave in a fragment or root of a tooth in order to avoid doing damage to adjacent structures such as nerves, sinuses, etc. or if an extensive risk of other complications is present with its removal.

NUMBNESS
Due to the proximity of roots to the nerve (especially wisdom teeth), it is possible to bruise or damage the nerve with removal of a tooth. This could remain for days, weeks, or very rarely, permanently. The lip, chin, cheek, gums and/or tongue could feel numb, tingling or have burning sensation.

SINUS INVOLVEMENT
Due to the location of the roots (especially the upper back teeth) to the sinus, it is possible for an opening to develop from the sinus to the mouth. Or a tooth/fragment may be displaced into the sinus. A possible infection and/or permanent opening from the mouth into the sinus could develop and may require medication and/ or later surgery.

JAW FRACTURE
Fracture of the jaw, usually in more complicated extractions.

QUALIFICATION
I understand that Dr. Brian Kumer is not an oral surgeon but a general dentist who has had several years experience in the extraction of wisdom teeth and always uses his best efforts to provide the appropriate treatment for his patients.

I hereby authorize **Dr. Brian Kumer** to perform the following procedures:
_____ on myself and to administer the necessary anesthetic. I understand the Doctor may discover other or different conditions that require additional or different procedures than those planned. I authorize him to perform such other procedures that are advisable in his professional judgment. I have read and discussed the risks that may occur in connection with this procedure. I believe I have been given and understand sufficient information to give my consent to the above surgery. I also acknowledge that the fees have been discussed with me and accept the fees as discussed.

DATE_____ **SIGNATURE OF PATIENT_____** **WITNESS _____**

SIGNATURE OF PARENT_____ **REV (JAN/2013)**