1st Impressions Dental and Denture
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CONSENT FOR ORAL SURGERY

____ I hereby authorize
Patient Name

____ and any associates
Doctor Name

To perform the following procedure ____

The doctor has explained to me the proposed treatment and anticipated teeth of such treatment I understand this is an effective problems and that the other forms of treatment including the options of the treatment.

The doctor has explained to the that there are certain potential risks in this treatment plan or procedure these include:

1. Injury to a nerve resulting in numbness of the chin, trip, cheek, gums and/or tongue on the operated side. This may persists for several weeks months or in remote instances permanently.
2. Postoperative infection requiring additional treatment.
3. Opening of the sums (a normal cavity situated above the upper teeth) requiring additional surgery.
4. Restricted mouth opening for several days or weeks, with possible dissociation of the temporomandibular (jaw) joint.
5. Injury to adjacent teeth and fillings.
6. In this circumstance, cardia….or breakage of the jaw.
7. Postoperative discomfort swelling and bleeding that may necessitate several days of recuperation.
8. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
9. Stretching of the co0ntains of the mouth with resultant cracking and bruising.
10. ____
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Unforeseen conditions may arise during the procedure that request a different procedure than set forth above I therefore authorize the doctor and any associates to perform such procedures when in their professional judgment, they are necessary.

I understand that the medication, drugs and prescriptions taken for this procedure may cause drowsiness and take of awareness and coordination I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile or hazardous devices while taking such medications and until fully recovered from their effects.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

Please don't hesitate to ask the doctor or staff if you have any questions.

____
Patient, parent or guardian

_______________________________ _______________________________
Doctor Date