Bichara
Periodontics & Dental Implants

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CONSENT FOR ORAL SURGERY

The purpose and nature of the surgical treatment described below have been fully explained to me. I have been fully informed of, and understand fully, the risks and benefits that normally result from and area involved in the performance of this treatment, alternative treatments, if any, to this form of treatment, and no treatment. I understand that there is a possibility of complications from the performance of this treatment that could include, without being limited to, infection and/or delayed healing, heavy bleeding that may be prolonged, swelling and/or bruising of the face and neck, stiffness of the jaw or jaw joint limiting mouth opening, injury to adjacent teeth and fillings, decision to leave a small piece of root in the jaw when its removal would require extensive surgery, fracture of the jaw, involvement of the maxillary sinus during or after treatment and possible numbness for an undetermined period of time. The numbness may include the lip, chin, gums, cheek, teeth and tongue areas, or any combination of them, as a complication of certain surgical treatments, particularly third molar surgery. I understand that the position of the nerves in these areas is such that this complication may be unavoidable. I have been told that, though this numbness is usually temporary, it may rarely be permanent.

I have been told that there will be anesthesia administered during this treatment. I have also been informed of the type and nature of such anesthesia, the alternatives to the administration of this anesthesia, the risks that are normally involved in the administration of this anesthesia and in administration of the alternatives to it, and the normal risks of the anesthesia itself and the alternatives to it. I hereby give my free and voluntary consent to the administration of this anesthesia during this treatment.

I hereby give my free and voluntary consent that this treatment and any other treatments or procedures which are deemed necessary or advisable by my doctor during the course of this treatment be performed upon me. I have not been given any promises or guarantees as to the results to be obtained from this treatment. I understand that I may refuse to consent to any and all treatments or procedures specified above or discussed with me.

I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction by Dr. Bichara.

I have informed my doctor of any special information regarding my health, or physical or mental condition, which may be relevant to the performance of this treatment upon me or the administration of this anesthesia to me. I have read the Consent Form and I understand it.

I hereby authorize Dr. Bichara, his associates and such assistants as may be selected by him, to perform the following procedure or treatment: _____

_____ _____
Please Print Patient Name Date

_____ _____
Signature (Patient, Parent/Legal Guardian Date

_____ _____
Doctor Signature Date