GULF COAST ORAL & MAXILLOFACIAL SURGERY, P.A.
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Please read carefully. Initial each line and bring back to surgery.

We feel it is our obligation to provide you with the best possible care. It is also our obligation to inform you of the risks associated with the proposed procedure. Please understand that the risks outlined below range from fairly common, such as postoperative swelling, to extremely rare, such as jaw fracture.

CONSENT FOR ORAL SURGERY

PLEASE INITIAL EACH LINE AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR **BEFORE** INITIALING.

_____ 1. This is my consent for the physicians and staff who are working with him/her to perform the following treatment/procedure/surgery:

_____
_____
_____

_____ 2. I understand that the purpose of the procedure/surgery is to treat and possibly correct my diagnosed condition. The doctor has advised me that if this condition persists without treatment or surgery, my present status may worsen in time, and there may be risks to my health. I have been informed of possible alternative methods of treatment, if any. I also agree to the use of local anesthesia.

_____ 3. The physicians have explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risk, include, but are not limited to:

_____ A. Postoperative discomfort and swelling that may necessitate several days of at-home recuperation.
_____ B. Heavy bleeding that may be prolonged.
_____ C. Injury to adjacent teeth and fillings.
_____ D. Postoperative infection requiring additional treatment.
_____ E. Stretching of the corners of the mouth with resultant cracking and bruising.
_____ F. Restricted mouth opening for several days or weeks, secondary to stress on the jaw joints (TMJ). existing TMJ problems may be worsened.
_____ G. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
_____ H. Fracture of the jaw – while very rare, it is possible with difficult of deeply impacted teeth.
_____ I. Injury to the nerve under the teeth resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side; this may persist for several weeks, months, or in rare instances, permanently.
_____ J. Opening into the sinus (a normal cavity situated above the upper teeth) requiring additional treatment.
_____ K. Dry socket.
_____ L. Allergic reactions (previously unknown) to any of the medications used in the procedure.
_____ M. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.

_____ 4. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile or hazardous devices for 24 hours or until fully recovered from the effects of same. If sedative drugs have been given to me at the time of surgery, I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after discharge from surgery.

_____ 5. Recognizing that during surgery some unforeseen condition may be discovered that might necessitate a change in approach or different procedure from those explained above, I authorize the physicians to perform such procedures as are necessary and advisable in the exercise of his/her professional judgment.

_____ 6. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that treatment would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

_____ 7. I have discussed my past medical history with my doctor and have disclosed all diseases and medications including alcohol and drug use (past or present). If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures I addition to or different from those now contemplated, I request and authorize the doctor to do whatever deemed advisable.

_____ 8. I agree to cooperate completely with the recommendations of the physicians, realizing that lack of cooperation may result in a less that optimal result. I have not been given any warranty or guarantee as to the result of the proposed procedure.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT AND THE EXPLANATION MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ANY APPLICABLE PARAGRAPHS WERE STRICKEN BEFORE I SIGNED. I ALSO STATE I SPEAK, READ, AND WRITE ENGLISH.

Patient's (or legal guardian's) signature Date

Witness' signature Date

Doctor's signature Date

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CONSENT FOR INTRAVENOUS ANESTHESIA

PLEASE INITIAL EACH LINE AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR **BEFORE** INITIALING.

You have chosen intravenous anesthesia for your surgery by your physician. Such anesthesia is quite common for oral surgery and is considered a safe procedure. Nevertheless, any anesthesia is not without some risks, and the common ones known for intravenous anesthesia are noted below for your review before you consent to its use.

_____ 1. Allergic reactions (previously unknown) to any of the medications used in the procedure.

_____ 2. Discomfort, swelling or bruising at the site where the intravenous drugs are placed into a vein.

_____ 3. Vein irritation, called phlebitis, where the needle is placed into a vein. Sometimes this may progress to a level where arm or hand motion may be restricted temporarily and medications may be required.

_____ 4. Nausea and vomiting, although not common, are unfortunate side effects of intravenous anesthesia. Bed rest, and sometimes medications, may be required for relief.

_____ 5. Intravenous anesthesia, although not as risky as general anesthesia, is a serious medical procedure and, whether given in a hospital or office, carries with it the risk of brain damage, heart attack, or death.

YOUR OBLIGATIONS

_____ 1. Because the anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you for several hours until you are recovered sufficiently to care for yourself. Sometimes the effects of the drugs do not wear off for 24 hours.

_____ 2. During the time of recovery (normally 24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

_____ 3. You must have a completely empty stomach. It is vital that you have **NOTHING TO EAT OR DRINK AFTER MIDNIGHT. TO DO OTHERWISE MAY BE LIFE-THREATENING!**

CONSENT: I have read and understand the above paragraphs and realize that intravenous anesthesia carries with it certain risks. I request that intravenous anesthesia be used for my surgery. All my questions have been answered fully to my satisfaction regarding this consent, and I fully understand the risks involved. I also state that I speak, read and write English.

_____

Patient's (or legal guardian's) signature Date

_____

Witness' signature Date

_____

Doctor's signature Date

ADDENDUM TO CONSENT FORM FOR PATIENTS USING ORAL CONTRACEPTIVES

Name:_____ Date:_____

It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed.

_____

Patient's signature Date

_____

Doctor's signature Date