Buttercup Dental

DISCLOSURE AND CONSENT – DENTAL AND ORAL SURGERY

To the patient: *You have the right, as a patient, to be informed about your condition and about the recommended surgical, medical, or diagnostic procedures to be used so that you may make a decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you can give or withhold your consent to the procedure.*

I voluntarily request Dr. Scott Smith, Dr. Darrell Park, Dr. Steven Stancey, Dr. Nicholas Oster, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me as:

Non-Restorable Periodontally-involved, and / or Impacted Teeth or

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I (we) understand that the following surgical, medical, or diagnostic procedures are planned for me (us), and I (we) voluntarily consent and authorize these procedures

Surgical Extraction of teeth or

I (we) understand that my doctor may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my doctor and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) understand that no warranty or guarantee has been made to me as to result or cure. I (we) have been given both oral and written post-operative instructions and I (we) agree to personally contact Dr. Smith / Park / Stancey / Oster in the event I (we) have a problem. I (we) will follow his instructions until that problem has been satisfactorily resolved. I (we) realize that in the event I (we) develop certain complications, I (we) may incur additional expenses, including but not limited to, expenses with other dentists, doctors or medical facilities.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures is the potential for infection, pain, swelling, bleeding, bruising, allergic reactions and even death. I (we) realize that the following risks and hazards may occur in connection with the particular procedure:

_____ 1. Swelling and/or bruising and discomfort in the surgery area.
_____ 2. Damage to adjacent teeth and/or dental restorations.
_____ 3. Soreness at injection sites and/or along veins, as well as discoloration of the injection sites, face, and/or jaws.
_____ 4. Dry Socket – jaw pain beginning a few days after surgery, usually requiring additional care.
_____ 5. Jaw fracture, muscle spasms and/or limited opening of jaws for several days or weeks
_____ 6. Stretching of the corners of the mouth resulting in cracking or bruising.
_____ 7. Possible infection requiring additional treatment.
_____ 8. Bleeding – significant bleeding is not common, but persistent oozing can be expected for several hours.
_____ 9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.

_____ 10. Incomplete removal of tooth fragments – to avoid injury to vital structures such as nerves or sinus, sometimes small root tips may be left in place.
_____ 11. Sinus involvement – the roots of upper back teeth are often close to the sinus and sometimes a piece of the root can be displaced into the sinus or an opening may occur into the mouth which may require additional care.
_____ 12. Jaw joint (TMJ) tenderness, soreness, pain or locking, which may be temporary or permanent.
_____ 13. Temporary or permanent nerve injury resulting in altered sensations or numbness in the lips, chin, tongue, teeth and/or gums.

I (we) have been given an opportunity to ask questions about my (our) condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used and the risks and hazards involved, and (we) believe that I (we) have sufficient information to give this consent.

ANESTHESIA OPTIONS:

Local Anesthesia: (Marcaine, Lidocaine, etc.) is given to block pain pathways in a localized area.

Local Anesthesia with Nitrous Oxide: Nitrous Oxide (laughing gas) helps to decrease uncomfortable sensations and offers some degree of relaxation.

Local Anesthesia with Oral Premedication or IV Sedation: Oral sedation is when a pill is taken for relaxation prior of giving local anesthesia. IV Sedation is administered by a licensed doctor intravenously and provides a deeper level of sedation. Whichever technique you choose, the administration of any medication involves certain risks, such as nausea and vomiting; an allergic or unexpected reaction. In addition, you may experience disorientation, confusion, or prolonged drowsiness after surgery.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in and that I (we) understand its contents.
I (we) agree not to drive home and to have a responsible adult accompany me (us) until I (we) have recovered from my medications. I (we) have given a complete and truthful medical history, including all medications, drug use, pregnancy, etc. I (we) certify that I speak, read and write English.

Date_____ Time_____

Signature of Patient or Other Legally Responsible Person

Patient's name (Please Print)

Witness _____ Date_____

Doctor _____ Date_____