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CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY

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Patient's Name _____

Date _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

Your diagnosis is: _____

Your Planned Treatment is: _____

Alternative treatment: methods include: _____

All surgeries have some risks. They include the following and others:

- ____ 1. Swelling, bruising and pain.
- ____ 2. Stretching of the corners of the mouth that may lead to cracking or bruising.
- ____ 3. Possible infection that might need more treatment.
- ____ 4. Dry socket - jaw pain beginning a few days after surgery, usually needing additional care.
- ____ 5. Possible damage to other teeth close to the ones being taken out, more often those with large fillings or caps.
- ____ 6. Numbness, pain, or changed feelings in the teeth, gums, lip, chin and/or tongue (including possible loss of taste). This is due to the closeness of tooth roots (mainly with wisdom teeth) to the nerves which can be injured or damaged. Usually the numbness or pain goes away, but in some cases, it may be permanent.
- ____ 7. Trismus – you can only open your mouth a little. This is most common after wisdom teeth are taken out. Sometimes it happens because of jaw joint problems (TMJ), mainly when TMJ disease is already there.
- ____ 8. There may be bleeding that is heavy or lasts a long time needing more treatment.
- ____ 9. Sometimes tooth roots may be left in to avoid harming important things such as nerves or a sinus (a hollow place above your upper back teeth).

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- _____ 10. The roots of the upper back teeth are often close to the sinus and sometimes a piece of root can get into the sinus. An opening may occur from the sinus into the mouth that may need more treatment.

- _____ 11. It is very rare that the jaw will break, but it is possible in cases where the teeth are buried very deep in their sockets.

- _____ 12. You may have an allergic reaction to a medication used in the treatment.

INFORMATION FOR FEMALE PATIENTS

- _____ 13. I have told my doctor that I use birth control pills. My doctor has told me that some antibiotics and other medications may reduce the preventive effect of birth control pills, and I could conceive and become pregnant. I agree to ask with my personal doctor to begin to use other forms of birth control during my treatment, and to continue those methods until my personal doctor says that I can stop them and use only oral birth control pills.

CONSENT

If my doctor finds a different condition than expected and feels that a different surgery or more surgery needs to be done, I agree to have it done.

I understand that my doctor can't promise that everything will be perfect. I have read and understand the above and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date