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CONSENT FOR PLACEMENT OF TEMPORARY ANCHORAGE DEVICE

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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 procedure is: _____

Alternative treatment methods include: _____

Placement of a temporary anchorage device (screws and / or plates) to assist in orthodontic treatment, whether easy or difficult, is still a surgical procedure. All surgeries have some risks and 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 require more treatment.
- ___ 4. Possible injury to roots of teeth close to the area of screw placement which might rarely need root canal treatment or a tooth might be lost.
- ___ 5. Possible loosening of a screw, requiring its removal and possible replacement of the screw in another location.
- ___ 6. Possible need to reposition or move a screw to a better location.
- ___ 7. Possible overgrowth of gum tissue requiring another procedure, or repeat procedures to reduce or remove the extra tissue.
- ___ 8. Possible injury to a nerve in upper or lower jaws, leading to numbness, pain, or changed feeling in the lips, chin, teeth, gums, and/or tongue. Usually the numbness or pain will go away, but in some cases it may be permanent.
- ___ 9. Possible bleeding or bruising. Bleeding is rarely serious, which might involve additional surgery to control.

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- ____ 10. The screws and/or plates are meant to be temporary and will require removal after completion of treatment. This may require a second incision to remove the device, and may involve stitches.

- ____ 11. A screw may break during placement or removal, and the _____ broken portion of the screw may be left in the bone.

- ____ 12. Despite correct surgical and orthodontic treatment, it is possible that the planned result may not be accomplished.

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 _____