Surgical Information Sheet and Consent Form

I understand that oral surgery includes possible inherent risks such as, but not limited to the following:

_____1. **Injury to the nerves:** This would include injuries causing numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face. This numbness could occur and may be of a temporary nature, lasting a few days, a few weeks; a few months; or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration associated with this procedure.

_____2. **Bleeding** heavy enough to stop the procedure. I also understand that bleeding may last several hours after the surgery. If bleeding is profuse, I should contact my dentist or go to the ER as soon as possible.

_____3. **Infection:** No matter how carefully surgical sterility is maintained, it is possible, due to the existing non-sterile or infected intraoral environment, infections may occur postoperatively. At times, infections may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon as possible should be received.

_____4. **Trismus** (inability to open mouth widely) could occur following surgery - especially by patients with a history of TMJ problems. Ice packs or heat packs can help, as well as gentle mouth opening/ stretching postoperatively.

_____5. **Sharp ridges or bone splinters** may form later at the edge of the hole where the tooth was taken out. This may require an additional surgery to correct.

_____6. **Injury to adjacent teeth or adjacent roots**: There is a possibility of injury to an adjacent tooth or to roots of teeth during the procedure which may require additional treatment.

_____7. **Infective endocarditis**: Because of the normal existence of microorganisms in the oral cavity, the tissues of the heart may be susceptible to microorganisms transmitted through blood vessels and infective endocarditis (an infection of the heart) could occur. Patients who have had a history of any heart conditions or heart surgeries should notify the dentist so your risk to this disease can be evaluated and minimized.

_____8. **Exposure of the sinus** or displacement of teeth/roots into anatomical spaces.

_____9. **Unusual reaction to medication** given or prescribed: Reaction, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescriptions drugs must be taken according to instructions in their entirety. Women using oral contraceptives must be aware that antibiotics that may be necessary to control infection can render these contraceptives ineffective. Other methods of contraception should be utilized during the treatment period.

_____10. **Necessity to leave tooth fragment(s)** in the oral cavity if removing the fragment(s) would pose a significant risk to vital structures.

_____11. **Stretching of the corners of the mouth** with resulting cracking and bruising or abrasions that might form a scab for a few days. Using shea butter lip protectants or cocoa butter can help.

_____12. It is my responsibility to seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given me.

_____14. **Hypersensitivity** could result from the removal of teeth and the exposure of the root of adjacent teeth. Particularly noticeable when drinking/eating cold items or brushing teeth.

_____15. **Breakage of jaw:** This is a very rare occurrence during the procedure. After surgery, you will need to avoid high impact activities for a period of time to avoid undue trauma to your jaw.

_____16. **Aspiration of teeth and restorations** into my lungs which could require x-rays, hospitalization, and further surgery.

_____17. Females only: I understand that if I am taking oral contraceptives, that any prescription of antibiotics given to me may interfere with the effectiveness of my birth control and that I should also utilize other means of birth control or abstinence during the time I am taking antibiotics.

Informed Consent: I have been given the opportunity to ask any questions regarding the nature and purpose of the surgical treatment I am receiving and have received answers to my satisfaction. Alternative treatment options (if any) have been discussed with me. I have discussed my health history with my dentist and have not withheld any information from him/her. I consent to the risks of the procedure as they have been explained to me. I understand the desired results may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. By signing this form, I am freely giving my consent to allow and authorize Dr. Wietholder and his staff members to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

_____ _____ _____

Patient's name (please print) Patient's Signature Date