INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA

1. This is my consent for Dr. Barresi and/or any oral and maxillofacial surgeon and assistant working with him to treat the following condition(s): ____________________________________________

2. The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure to be: ____________________________________________

3. I understand that the purpose of the elective procedure/surgery is to treat and possibly correct my diseased oral/maxillofacial tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen with time, and the risks to my health may include, but are not limited to the following: swelling, pain, infection, cyst or even tumor formation, periodontal (gum) diseases, dental caries, malocclusion, pathological fracture of jaw, premature loss of teeth and/or bone. I have been informed of the possible alternative methods of treatment, if any.

4. I further understand that this is an elective procedure and other forms of treatment or no treatment at all are choices that I have.

5. The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that the risks of oral and maxillofacial surgical procedures include, but are not limited to:

   A. Post-operative discomfort and swelling that may necessitate several days of home recuperation
   B. Heavy bleeding that may be prolonged and require additional treatment
   C. Injury to adjacent teeth and fillings requiring further treatment
   D. Post-operative infection requiring additional treatment
   E. Stretching of the corners of the mouth with resultant cracking, bruising and sores
   F. Restricted mouth opening for several days or weeks
   G. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery
   H. Breakage of the jaw
   I. Injury to the nerves underlying the teeth resulting in numbness, tingling or pain of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side: this may persist for several weeks, months, or in rare instances be permanent
   J. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery
   K. If intravenous medication is used, soreness at the injection site or along the vein may develop, as well as discoloration of the injection site and possible vein inflammation
   L. Temporo-mandibular joint (TMJ, jaw joint) and muscle spasm problems can occur after oral and maxillofacial surgery procedures which may require additional treatment(s). Ear aches and worsening of pre-existing temporo-mandibular joint problems can occur.
   M. I understand that certain anesthetic risks, which could cause serious bodily injury, including cardiac arrest, are inherent in any procedures that require general anesthetic
   N. Other: ____________________________________________
6. I agree and understand that I am not to have and/or have not had anything to eat or drink for at least five hours before my surgery if general anesthesia or sedation are to be used.

7. I consent to the administration of anesthesia, including local, intravenous, and/or general anesthesia in connection with the procedure(s) referred to above and to the use of such anesthetics as may be deemed advisable by Dr. Barresi, his associates or assistants.

8. Medication, 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. I have been advised not to operate any vehicle, automobile or hazardous devices, or work, while taking such medications and/or drugs until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four (24) hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge.

9. 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 a risk of failure, relapse, selective retreatment, or worsening of my present condition despite the care provided. However, it is the doctor’s opinion that therapy would be helpful, and that a worsening of my condition could occur without the recommended treatment.

10. I have had the opportunity to discuss with the doctor my past medical and health history including any serious problems and/or injuries.

11. I agree to cooperate completely with the recommendations of the doctor while I am under his care, realizing that lack of same could result in a less than optimum result.

12. The fee for services has been explained to me and is satisfactory.

I CERTIFY THAT I READ AND WRITE ENGLISH AND THAT I FULLY UNDERSTAND THE ABOVE CONSENT.

Patient, Parent or Guardian  Date

Doctor  Date