BAY COLONY DENTISTRY
A Divison of Atlantic Dental Care, PLC
making the world brighter one smile at a time

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ORAL SURGERY INFORMED CONSENT

As a patient scheduled to have surgery involving my teeth, surrounding bone and/or soft tissue,

I, (patient name) _____ understand that the purpose is to treat and possibly correct my diseased oral tissues. I realize that without treatment my present oral condition will probably worsen in time and risks to my health may include but are not limited to the following: swelling, pain, infection, cyst formation, periodontal (gum) disease, dental caries, malocclusion, pathologic fracture of the Jaw, premature loss of teeth, and/or premature loss of bone. I understand the possible alternative forms of treatment, if any, but have freely chosen the planned procedure. am aware that in any surgical procedure, there are inherent and potential risks. understand that in this instance such operative risks include, but are not limited to:

- Postoperative swelling and discomfort which may necessitate several days of home recuperation.
- Heavy blooding that may be prolonged and/or require medical or surgical treatment and blood transfusion.
- Injury to adjacent teeth, fillings, or restoration.
- Postoperative infections that may require additional treatment.
- Stretching, crackling, and/or bruising of mouth that may heal slowly.
- Limitation of Mouth opening or chewing ability due to adverse effects on the jaw joint.
- The decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
- Breakage or fracture of the jaw or disabling injury to the jaw joints.
- Injury to the nerves in the area that can result in numbness, tingling or pain in the lip, chin, gums, cheek, teeth, and/or tongue.
- Involvement of the sinus in the upper jaw, resulting in an opening into the mouth that may require additional surgery.
- Inability to function normally (work, school, domestic) during surgical recovery period.
- Bone loss around the extraction site if socket preservation with bone graft materials and placement are not completed as recommended.

Medications including local anesthetic: Medications including local anesthetic can cause allergic and other reactions. Examples include, but are not limited to, swelling, redness, itching, vomiting, diarrhea, and numbness, or tingling of the lip, gum, or tongue (which in rare cases may be permanent), as well as, in rare cases, anaphylactic shock. Since anxiolytic drugs cause drowsiness and impair coordination or awareness, patients should not operate a motor vehicle or hazardous device before achieving full recovery. I have informed the dentist of all drugs and medications I am taking or have taken within the last 30 days, as well as those that have been prescribed within the last six months but not taken, and of all allergies and sensitivities of which I am aware. I have been informed and understand that failure to take drugs or medications as prescribed by my dentist may result in continued or aggravated infection and pain, and potential resistance to effective treatment. I also understand that antibiotics can reduce the effectiveness of birth control pills.

_____I have discussed treatment alternatives, risks, outcomes, and costs with my dentist and have had all my questions answered before making a decision. I understand that dentistry is not an exact science and that there are no guaranteed results. Unless otherwise provided by law,

_____I understand that I am responsible for payment of all dental fees not paid in full by any insurance or other applicable coverage.

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Having had adequate time to reflect upon the alternatives, I consent to the treatment, subject to changes in the treatment plan. I hereby authorize Bay Colony Dentistry staff and Deborah R. Blanchard, DDS, MAGD to release information pertaining to my treatment to my insurance company.

Planned Procedure:_____

- ☐ I certify that I read and write English and have read and fully understand this consent for surgery and local anesthetic and nitrous oxide (laughing gas). I have asked the doctor any questions I have concerning this consent form and they have been answered to my satisfaction.

- ☐ I do not speak English. This informed consent has been verbally translated for me by:

_____ _____
Translator Name Relationship

_____ _____
Patient Name Date

_____ _____
Patient Signature Witness