

I. RECOMMENDED TREATMENT

I give my permission for Health Partners of Western Ohio to perform the treatment listed below using local anesthesia, as well as any additional procedures found to be necessary during the oral surgery. This permission is for me (or my child/ward): _____.

The surgical treatment to be performed is:

II. TREATMENT ALTERNATIVES

I have agreed to the treatment listed above. I have been informed about the treatment alternatives and I completely understand these options listed below:

Alternatives: _____

III. RISKS AND CONSEQUENCES

I understand that there are risks and consequences associated with the administration of medications, including anesthesia, and performance of the recommended surgery. These can be, but are not limited to the following:

1. Drug reactions and side effects.
2. Post-operative pain, bleeding, oozing, infection and/or bone inflammation are possible.
3. Restricted mouth opening, bruising and/or swelling, for several days or weeks can occur.
4. Removal of bone during tooth extraction.
5. Damage to adjacent teeth or tooth restorations.
6. Root tips sometimes break during the oral surgery process. These root tips may be left in the bone to avoid more aggressive surgery. However, this more aggressive surgery may be needed and you may be referred to another provider for this procedure.
7. Delayed healing, including but not limited to, dry socket, necessitating post operative care.
8. Possible involvement of the sinus during the removal of the upper posterior teeth, which may require additional treatment or surgical repair at a later date.
9. Possible involvement of the nerve of the lower jaw during the removal of the lower back teeth resulting in temporary or permanent tingling / numbness of the lower lip, chin, tongue or other surrounding structures.
10. Jaw fracture.
11. If you are taking medications to make your bones stronger (such as bisphosphonates), medications for the treatment of cancer, or if you have received radiation therapy to the head or neck area for tumors / cancer, you are at a higher risk for poor bone healing or bone death that may never completely resolve.

IV. CONSENT

I fully understand this informed consent form for oral surgery and I also understand the reasons why the treatment was recommended to me. I have been given satisfactory answers to all of my questions. I understand that no guarantee of outcome has been made or implied regarding the treatment.

Patient Name (Print Please)	Patient/Parent or Guardian Signature	Date
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Dentist Name (Print Please)	Dentist Signature	Date
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