

INFORMED CONSENT ORAL SURGERY AND DENTAL EXTRACTIONS

I UNDERSTAND that ORAL SURGERY and/or DENTAL EXTRACTIONS include possible inherent risks such as, but not limited to the following:

1. **Injury to the nerves** of the lips, the tongue, the tissues in the floor of the mouth, and/or the cheeks, etc. These possible nerve injuries can cause numbness, tingling, burning, and loss of taste in the case of the tongue which may be of a temporary nature lasting a few days, a few weeks, a few months, or could possibly be permanent.
2. **Bleeding and/or bruising:** Bleeding could last for several hours. Should it persist, particularly being severe in nature, it should receive attention and this office must be contacted. Bruising may possibly be prolonged.
3. **Dry socket** occurs on occasion when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful. Smoking, drinking liquids through a straw and not following post-operative recommendations can increase the chances of this complication.
4. **Sinus involvement:** In some cases, the root tips of upper teeth lie in close apposition to the tissues of the sinuses. During extraction or surgical procedures, the thin bone and tissues surrounding the sinus membrane may be perforated. Should this occur, it may be necessary to have the sinus surgically repaired.
5. **Infection:** No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile or infected oral environment, for infections to occur postoperatively. At times these may become serious. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon as possible should be received and this office must be contacted. In some cases hospitalization and/or treatment with IV antibiotics may become necessary.
6. **Fractured jaw, roots or bone fragments:** There is a possibility, even though extreme care is exercised, that the jawbone, teeth roots or bone spicules may be fractured which may require referral to a specialist for treatment. A decision may be made to leave a small piece of root or bone fragment in the jaw when its removal would require extensive surgery and/or risk of complications.
7. **Injury to adjacent teeth, fillings or porcelain crowns** may occur no matter how carefully surgical and/or extraction procedures are performed. Fractured fillings or crowns may require replacement.
8. **Bacterial endocarditis:** Because of the normal existence of bacteria in the oral cavity, the tissues of the heart in some cases and due to a number of conditions may be susceptible to bacterial infection transmitted from the mouth to the heart through the circulatory system. A condition called bacterial endocarditis (infection of the heart) may occur which can result in damage to heart valves. If any heart problems are known or suspected (such as a heart murmur following rheumatic fever, existence of an artificial heart valve, cardiac damage following PhenFen use, etc.), the dentist must be informed prior to surgery.
9. **Muscle or jaw soreness** may be noticed following oral surgery and especially third molar extractions. Pre-existing conditions affecting the jaw joints (TMJ) may be aggravated by oral surgery. Clicking, popping, muscle soreness and difficulty opening may be noticed for some time following surgery. If such symptoms or conditions persist, the patient should call our office. The patient must notify the dentistry of any such pre-existing conditions prior to surgery.
10. **Unusual reactions to medications given or prescribed:** Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It is important to take all prescription drugs according to instructions. Women on oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Caution must be exercised to utilize other methods of contraception during the treatment period.
11. **BISPHOSPHONATES Drug Risks:** For patients who have taken drugs such as Fosamax, Actonel, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any oral surgical procedure involving bone, including extractions.
12. **It is my responsibility to contact the dentist and seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given me.**
13. **I UNDERSTAND THAT DR. HENDRICKSON IS A CERTIFIED GENERAL DENTIST LICENSED TO PERFORM ORAL SURGERY AND THIRD MOLAR REMOVAL. I ALSO UNDERSTAND THAT HE IS NOT AN ORAL AND MAXIFOFACIAL SURGEON. I CHOOSE NOT TO BE REFERRED TO AN ORAL AND MAXIFOFICIAL SURGEON FOR THIS PROCEDURE.**

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and/or extraction of teeth and have received answers to my satisfaction. I have been given the option of seeking care with an oral and maxillofacial surgeon. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Hendrickson and/or his associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient's Name (Please Print)

Signature of patient, legal guardian or authorized representative

Date

Witness to Signature

Date

I.V. SEDATION/ANESTHESIA

I **UNDERSTAND** that undergoing **ANESTHESIA/I.V. SEDATION** includes possible inherent risks such as, but not limited to the following:

1. **COMPLICATIONS OF THE DRUGS AND ANESTHESIA**, which include but are not limited to: tenderness, bruising, nausea, vomiting, swelling, bleeding, infection, numbness, allergic reaction, stroke, and heart attack.
2. **BRUISING OR TENDERNESS OF THE I.V. INDUCTION SITE** may occur. Some sedative agents may cause a burning or itching sensation in the wrist or arm during induction. Edema may be caused when excess I.V. fluid enters surrounding tissues and may take several days to resolve. Sometimes phlebitis (inflammation of the venipuncture site) may require additional treatment. Tenderness/edema can be treated with warm moist heat applied to the site.
3. **NEED FOR LIMITATION OF FOOD OR DRINK.** I understand that the patient must refrain from any food or drink 8 hours for heavy meals, 6 hours for light meals (toast, and OJ) 2 hours for clear liquids (water, apple juice no pulp) prior to their appointment. Further instructions may be given by the dentist or anesthetist or anesthesiologist depending on the procedures to be performed and other factors.
4. **CHANGES IN HEALTH ARE IMPORTANT**, including fevers or “common colds.” I am expected to convey this information to the dentist prior to a planned appointment when sedation/anesthesia is involved.
5. **A RESPONSIBLE ADULT MUST ACCOMPANY THE PATIENT AT THE TIME OF DISCHARGED**, and I understand that the patient must not drive a vehicle or take a bus or taxi after undergoing I.V. sedation/anesthesia.
6. **WOMEN:** Anesthetics, medications and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion, and I accept full responsibility for informing the dentist or attending anesthesiologist of anesthetist of a suspected or confirmed pregnancy.

INFORMED CONSENT: I have been given the opportunity to ask my questions regarding the nature and purpose of I.V. sedation/anesthesia and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, or even death which may be associated with any phase of receiving I.V. sedation/ anesthesia in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Hendrickson and Greg Sanders CRNA and/or their associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications, for my own benefit or the benefit of my minor child or ward. I understand that the attending anesthesiologist may request that I sign an additional informed consent generated by their office.

Patient's Name (Please print)

Signature of patient, legal guardian or authorized representative

Date

Witness to Signature

Date