

Informed Consent for Oral Surgery and Anesthesia

Record Number
Patient Name (Last, First, MI)
Date of Birth (YYMMDD)

Please initial each paragraph after you have read and understand it as indicated.

ITEM

(1) Diagnosis

(2) Treatment Plan

(3) Anesthesia Plan: Local, Local and N2 O/O2, Other

(4) I understand that the purpose of the treatment or surgery is to treat and possibly correct my diseased oral and/or jaw structures. The students and/or faculty has advised that if this condition persists without treatment or surgery, my present oral condition may worsen in time, and the risks to my health may include, but are not limited to, the following: pain; swelling; bleeding; infection; cyst formation; periodontal (gum) diseases; dental carries; injury to jaws; premature loss of bone.

(5) I have been informed of possible alternative methods of treatment.

(6) The student and/or faculty has explained to me that there are certain inherent and potential risks in my treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to, any of the following:

- (A) Postoperative discomfort and swelling that may necessitate several days of home recuperation
(B) Persistent bleeding or drainage
(C) Injury to adjacent teeth, fillings, bone, lips, tongue and other tissues
(D) Postoperative infection requiring additional treatment
(E) Stretching of the corners of the mouth with resultant cracking and bruising
(F) Restricted mouth opening for several days or weeks
(G) Decision to leave a small piece of root in jaw when it's removal would require extensive surgery
(H) Breakage of the jaw and its subsequent treatment which may require wiring the jaws together
(I) Injury to the adjacent nerves resulting in numbness or altered sensation, tingling of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side: this may persist for several weeks, months, or in remote instances, permanently.
(J) Opening into the maxillary sinus (a normal cavity situated above the upper teeth) requiring additional surgery
(K) Problems with local anesthesia, though rare, could include pain, swelling, bruising, infection, nerve damage, and unexpected allergic reactions which could result in a heart attack, stroke, brain damage and/or death
(L) Other:

(7) I agree to the use of nitrous oxide sedation in conjunction with my surgical treatment. The risks and complications with this type of sedation have been explained to my satisfaction.

## IV or GA Anesthesia Plan

- \_\_\_\_\_ (8) As part of my treatment plan I agree to the use of IV sedation or general anesthesia, in addition to local anesthesia and/or nitrous oxide sedation, as agreed upon by myself and my doctor(s). I have been given the choice of a local anesthetic alone for the proposed surgery. The risks and complications associated with IV sedation or general anesthesia have been explained to me.
- \_\_\_\_\_ (9) I agree and understand I am not to have and/or have not had anything to eat or drink for 6 hours before my surgery and general/IV sedation anesthetic. I understand that to do otherwise may be life threatening.
- \_\_\_\_\_ (10) 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; thus, 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 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 from surgery.
- \_\_\_\_\_ (11) Problems may occur adjacent to the IV (intravenous needle) site and may include pain, swelling bruising, infection or scarring of the vein.
- \_\_\_\_\_ (12) I understand that certain anesthetic risks, which could involve serious bodily injury are inherent in any procedure that requires a general anesthetic.

\_\_\_\_\_ (13) I have viewed the informed consent video on Third Molar Surgery detailing the risks and complications associated with my surgical treatment and the IV sedation or general anesthesia plan I have accepted.

- \_\_\_\_\_ (14) 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 re-treatment, or worsening of my present condition despite the care provided. However, it is my doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.
- \_\_\_\_\_ (15) If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever s/he may deem advisable.
- \_\_\_\_\_ (16) I agree to cooperate completely with the recommendations of the doctor(s) named above, while I am under their care, realizing that any lack of same could result in a less than optimum result.

I certify that I have had an opportunity to read and fully understand the terms and words within the above consent to the operation and the explanation referred to or made, and that all statements requiring insertion or completion were filled in before I signed. I willingly authorize the University of Minnesota Dental Clinics to provide the treatment indicated.

Signature - Patient, Parent or Guardian	Printed Name	Date
Signature - Student Dentist/Resident	Printed Name	Date
Signature - Faculty	Printed Name	Date