CACHE VALLEY
WISDOM TEETH

Tooth Extraction Informed Consent

_____ _____
Patient's Name Date of Birth

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. You have been informed of your diagnosis, the planned procedure, the risks and benefits, alternatives associated with the procedure, and any associated costs. Before deciding whether to proceed with the planned procedure, you should consider all of the above, including the option of declining treatment. Your doctor will be happy to answer any questions you may have and provide additional information before you decide to sign this document and proceed with the procedure.

The procedure being performed is: _____

1. I have been informed of and understand that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to:

    - Pain, swelling, bruising, prolonged bleeding, delayed healing, injury to adjacent teeth and fillings that may result in tooth repair or loss, loose tooth/teeth or damage to dental appliances, stretching of the corners of the mouth with resultant cracking and bruising and/or cuts inside the mouth or on the lips, fracture of the jaw, stress or damage to the jaw joints (TMJ), limited mouth opening or difficulty chewing for several days or weeks;
    - Post-operative infection requiring additional treatment;
    - Decision to leave a small piece of root in the jaw when its removal would require extensive surgery;
    - Nerve injury which may occur from the surgical procedure and/or delivery of local anesthesia, resulting in numbness, tingling or altered sensation of the chin, lip, cheek, gums, and tongue (including loss of taste) on the operated side. This may persist for several weeks, months, or in rare instances, be permanent;
    - Opening in the sinus (a normal cavity situated above the upper teeth) requiring additional treatment;
    - Dry socket (slow healing) resulting in jaw pain that increases a few days after surgery;
    - Sharp ridges or bone splinters may form where the tooth was removed possibly requiring additional surgery.

2. I have elected to proceed with the anesthesia(s) indicated below:
    - □ Local Anesthesia
    - □ Nitrous Oxide (Laughing Gas)
    - □ IV Sedation

I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:

- Allergic or adverse reactions to medications or materials;
- Pain, swelling, redness, irritation, numbness and/or bruising in the area where the IV needle is placed. Usually the numbness or pain will resolve, but in some cases it may be permanent;
- Nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness. Some patients may have awareness of some or all of the events of the surgical procedure after it is over;
- Heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest) or death;
- Sore throat or hoarseness if a breathing tube is used;
- **Due to the potential for nausea and vomiting under anesthesia, I understand that I am not to eat or drink <u>anything</u> (or have not had anything) by mouth for at least 6 to 8 hours before my surgery. TO DO OTHERWISE MAY BE LIFE THREATENING!**

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If I have elected for IV sedation, I have been instructed to take my regular medications and/or any other medication given to me by my doctor before surgery using only small sips of water. I have been made aware that medications given during surgery and prescriptions I may be given can cause drowsiness and/or lack of awareness which may be worsened by the use of alcohol and other drugs. I have been advised not to operate any vehicle or hazardous machinery and not to work while taking such medication or until fully recovered from the effects of the same. I understand this recovery may take up to 24 hours or more after the last dose of medications. If I am to be given sedative medication during my surgery, I agree not to drive myself home, and I will have or do have a responsible adult to drive me home and accompany me until I am fully recovered from the effects of the sedation.

If I am a female using oral contraceptives, I understand that I will need to use additional forms of birth control for one complete cycle of birth control pills, as antibiotics and other medications may interfere with the effectiveness of oral contraceptives.

I have been informed of and understand that follow-up visits or care, additional evaluation, treatment or surgery, and/or hospitalization may be needed.

If any unforeseen condition should arise in the course of the operation and while under anesthesia, I further authorize the doctor to modify the procedure if, in his professional judgment, it is in my best interest.

In order to increase the chance of receiving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable) and have had the opportunity to discuss this with Dr. Burns. I agree to cooperate completely with the recommendations of Dr. Burns while I am under his care, realizing that any lack of the same could result in a less than optimal result. I understand that Dr. Burns is not an oral and maxillofacial surgeon and is also not an anesthesiologist.

It is my responsibility to seek attention should any circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given to me.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and have received answers to my satisfaction. I 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 results of the treatment or my recovery. By signing this form, I am freely giving my consent to allow and authorize any treatment necessary or advisable to my own or my child's dental conditions, including any and all anesthetic and/or medications.

PLEASE ASK DR. BURNS IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM.

Patient's (or legal guardian's) signature Date

Witness' signature Date

Doctor's signature Date