CONSENT FOR TREATMENT

I, _____

hereby authorize Dr. (s) _____

to perform the following procedure(s) _____

_____

I am also aware that the procedure will involve the use of local anesthetic and/or general anesthetic (intravenous sedation).

I realize that there are risks involved in this operation and in the anesthetic process. Some of the complications and risks include, but are not limited to:

1. Bleeding and swelling
2. Post operative infection requiring additional treatment
3. Trismus - the inability to open mouth wide
4. Postoperative nausea and vomiting
5. Injury to the adjacent teeth and fillings
6. Decision to leave a small root in the jaw when removal would be detrimental
7. Opening of the sinus when removing upper teeth requiring additional treatment
8. Thrombophlebitis - soreness at the injection site in arm
9. Jaw fracture
10. Numbness in the lower lip, chin, or tongue following removal of lower teeth
11. Cardiac arrest
12. Temporomandibular joint soreness or pain

13. Other: _____

I further understand that this is an elective procedure and other forms of treatment, or no treatment at all, are the choices I have. I am satisfied with the explanation of the operation, risks and/or possible alternative treatment. I specifically consent to the procedure outlined above and I authorize the above mentioned doctor(s) to perform such other procedures as may be necessary in his judgement if such need arises in the course of this treatment. Also no guarantee has been made to me as to the procedure outlined above.

_____ _____

Signature of patient/POA/Other Date

_____ _____

Witness Date