N O R T H E A S T

Oral & Maxillofacial Surgery Center

9310 Two Notch Road Columbia, SC 29223 (803) 699-5900

Diplomats, American Board of Oral and Maxillofacial Surgery

Jeffery Dootson, DMD Stephen E. Clary, DDS Karen Tucker, DDS, MD Matthew Nimmich, DMD

Patient Name:_____

INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA**

This is my consent form for Drs. Jeffery Dootson/Stephen E. Clary/Karen Tucker/James W. Strider/ and/or any oral & maxillofacial surgeon who is working with them to perform the following treatment/procedure/surgery:

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as previously explained to me, or any other procedure deemed necessary or advisable as necessary to complete the planned operation. I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral/maxillofacial tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will possibly worsen in time, and the risks to my health may include, but are not limited to, the following: swelling; pain; infection; cyst formation; periodontal (gum) diseases; malocclusion; pathologic fracture of the jaw; premature loss of teeth; and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

____ The doctor has explained to me 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:

_____ 1. Postoperative discomfort and swelling that may necessitate several days of home recuperation.

_____ 2. Heavy bleeding that may be prolonged.

_____ 3. Injury to adjacent teeth and fillings.

_____ 4. Postoperative infection requiring additional treatment.

_____ 5. Stretching of the corners of the mouth with resultant cracking and bruising.

_____ 6. Restricted mouth opening for several days or weeks.

_____ 7. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.

_____ 8. Breakage of the jaw.

_____ 9. Injury to the nerve underlying the teeth resulting in numbness, 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.

____10. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

____11. Dry socket (loss of natural blood clot in socket).

____12. I understand I must have an escort bring me to the office, **STAY** during the procedure and take me home or my surgery cannot be accomplished.

____13. I have been made aware of Bisphosphonate related osteonecrosis of the jaws (chronic bone infection).

Other_____

(over)

____ I agree and understand I am not to have **anything to eat or drink (to include <u>water or any other liquids</u>) for at least 8 hours before** my oral surgery. General anesthesia cannot be administered unless this is the case.

____ I consent to administration of such local and/or general anesthesia, sedation and analgesia as deemed necessary for Drs. Dootson/Strider/Tucker/Clary and/or designated assistants to accomplish the proposed procedures.

____ Medications, 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, or until fully 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 my discharge from surgery.

____ I understand that certain anesthetic risk, which could involve serious bodily injury, are inherent in any procedure that requires a general anesthetic or sedation.

____ 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 he may deem advisable.

____ No guarantee or assurance has been given 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 the doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

____ I have had an opportunity to discuss with Drs. Dootson /Strider /Tucker/Clary my past medical and health history and fully disclosed all medications that I am presently taking, all allergies to drugs and foods, and any serious problems and/or injuries.

____ I agree to cooperate completely with the recommendations of Drs. Dootson /Strider /Tucker /Clary while I am under his care, realizing that any lack of same could result in a less than optimum result.

_____**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT FOR THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OF STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY WERE STRICKEN BEFORE I SIGNED. I ALSO STATE I READ AND WRITE ENGLISH.**

_____ _____ _____

Witness Patient, Parent or Guardian Date

_____ _____

Witness Drs. Jeffery Dootson/Stephen E. Clary/Karen Tucker/James W. Strider, Jr.

***Patient is to initial each paragraph after reading.**