SCOTT FAMILY DENTISTRY
& Laser Skin Solutions
www.scottfamilysmiles.com
605-665-2448

Informed Consent For Oral and Maxillofacial Surgery

Procedures: Surgical removal of tooth/teeth number(s): _____

Alternatives to Surgery: Risks to my health if the above procedure is not performed include but are not limited to:

- Infection
- Cyst or tumor formation
- Periodontal (gum) disease
- Increased risk for complications if removal is required at a later time.

Possible Complications which have been discussed with me include but are not limited to:

1. Injury to the nerves, to the lower lip, and tongue causing numbness which could be permanent

2. Bleeding and/or bruising which may be prolonged

3. Dry socket

4. Involvement of the sinus above the upper teeth

5. Infection

6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and increased risk of complications

7. Injury to adjacent teeth or fillings

8. Unusual reaction to medications given or prescribed

I understand that a perfect result cannot be guaranteed. If any unforeseen conditions arise during the procedure, I request and authorize the doctor to do whatever she deems advisable to correct the condition. I agree to cooperate completely with Dr.Scott, and will follow post-operating instructions to the best of my ability for my own comfort and safety. I have had the opportunity to ask questions concerning these procedures. I attest that I have informed Dr. Scott of any recent head or neck trauma norI have I had any history of bisphosphonate treatment.

_____ _____

Patient, Parent or Guardian Date