

Family Smile Center, LLC
5950 Frederick Crossing Lane, Suite 201
Frederick, MD 21704
301-663-9484

INFORMED CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY

Procedure: Surgical removal of **wisdom teeth**

Alternatives to surgery: Risks to my health if these teeth are not removed include, but are not limited to:

1. Infection
2. Cyst or Tumor Formation
3. Periodontal (Gum) Disease

Possible complications from the procedure discussed with me include, but are not limited to:

1. Injury to the nerves to the lower lip and tongue causing numbness, which could possibly be permanent.
2. Prolonged bleeding and/or bruising.
3. Dry socket.
4. Involvement of the sinus above the upper teeth.
5. Infection.
6. Decision to leave 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.
9. _____.

Anesthesia: I may receive nitrous oxide (laughing gas) to make the surgery more comfortable. This is at an additional charge of \$157.00 an hour. I haven't had anything to eat or drink for 4 hours.

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 he deems advisable to correct the condition including referral to specialists.

I agree to cooperate completely with the doctor and will follow post-operative instructions to the best of my ability for my own comfort and safety. I have had the opportunity to ask questions concerning these procedures. All of my questions have been answered.

Signature of Patient, Parent, or Guardian

Date

Doctor's Signature

Witness

