FAMILY SMILE CENTER,LLC

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CONSENT TO SURGERY

Our practice is committed to providing our patients with the finest care possible. We strive for the very best results but healing can vary from person to person. We must inform you of the possible risks associated with the surgery and the alternatives to treatment.

SURGICAL PROCEDURE

□ Extraction: Tooth/ Teeth (including 3rd molars)
□ Dental Implant Placement
□ Ridge/ Sinus-lift Bone Graft
□ Socket Bone Graft
□ Soft Tissue (Gum) Graft
□ Frenectomy
□ Pocket reduction procedure
□ Bone grafting to preserve teeth and their attachment
□ Crown Lengthening
□ Apical Surgery
□ Gum Contouring for Cosmetics
□ Biopsy
□ Other _____

In order to treat my current dental condition, Dr. _____ has recommended that my treatment may include the surgical procedure noted above. I understand that local anesthetic will be administered to me as part of treatment. I have been informed and I understand the purpose and nature of the procedure I am about to receive. My doctor has carefully examined my mouth, and alternatives to this treatment have been explained. I have tried or considered other methods, but I choose this treatment option.

I understand that antibiotics, growth factors and other substances may be applied to the teeth and/or surgical site. I consent to the use of soft tissue and/ or bone graft material either from myself, or from other sources (ex: bovine, porcine, synthetic, or cadaveric) for treatment. The material that will be used (other than my own) has been tested for viruses and bacteria by the most sophisticated and reliable methods available today. I further understand that unforeseen circumstances may call for modification or termination from the anticipated surgical plan.

RISKS AND COMPLICATIONS

I understand that a small number of patients do not respond successfully to periodontal, oral, endodontic, or implant surgery. In such cases, the involved teeth, bone, tissue, or implants may be lost. The surgery may not be successful in preserving, augmenting, and/ or achieving function or

esthetics. Additional procedures may need to be performed if the initial results are not satisfactory. Each patient's condition is unique and long- term success may not occur. I understand that my medical/ health conditions, medications that I am taking, diet and nutritional problems, clenching/bruxing of my teeth, excessive smoking, alcohol, or sugar may affect healing, and may limit the success of treatment.

I have been informed of the possible risks and complications involved with surgery, drugs and anesthesia. Such complications include pain, swelling, infection, bruising, temporary or permanent numbness of the lip, tongue, chin, cheek or teeth, inflammation of vessels, injury to teeth, restricted mouth mobility, gum recession (shrinkage), interference with speech, severe tooth sensitivity (temporary or permanent), which may require endodontic treatment for sensitivity relief, increased tooth looseness, food impaction between teeth after eating, unaesthetic exposure of crown (cap) margins, accidental swallowing of foreign matter, bone fractures, damage to adjacent teeth, sinus penetrations, delayed healing, allergic reactions to medications, and other unforeseen complications.

PATIENTS WHO HAVE RECEIVED BISPHOSPHONATES

I understand that if I have been treated with oral bisphosphonate drugs or radiation treatment to the jaw bone then there is a risk of severe complications with any dental treatment. Bisphosphonate drugs or radiation treatment to the jaw bone affect its healing capability. Osteonecrosis (dying of bone cells) or infection of the bone or soft tissue may occur, resulting in severe jaw destruction that could require multiple reconstructive surgeries, ongoing intensive therapy, hospitalization, long term antibiotics, and removal of dead bone.

ALTERNATIVES TO TREATMENT

I understand that without treatment any of the following could occur; bone disease, loss of bone, gum tissue inflammation, sensitivity, looseness of teeth, tooth loss, limited function, diminished aesthetics, temporomandibular joint (jaw) problems, headaches, referred pains to the back of the neck and facial muscles, severe infection that can be fatal and other unforeseen events.

Alternatives to implant related procedures such as partial dentures and fixed bridges, or no treatment have been discussed. I understand the reasons I have chosen this treatment. I understand that my prosthodontic dental treatment such as crowns or dentures on the implants will involve a separate fee.

HOME CARE

I will come for appointments following my surgery as instructed so that my healing may be monitored, and prosthesis adjusted if necessary. It has been explained to me that the long-term success of treatment requires my cooperation and performance of plaque control (home care) as instructed at least twice a day, as well as periodic dental maintenance visits. I understand that failure to follow such recommendations could lead to ill effects, which would be my sole responsibility.

PREGNANCY

I understand that the medications and drugs may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing my health care provider of a suspected or confirmed pregnancy. For the same reason I understand that I must inform if I am a nursing mother. Local anesthetic containing epinephrine (lidocaine) is considered

a class B drug, and is approved for use in pregnancy according to the American Dental Association. However, long term studies have not been performed.

OUT OF TOWN

It is advised that, within the two-week time frame after your procedure, that you do not make any travel plans to ensure that if anything should happen during your healing process, you are capable of getting into the office on an emergency basis.

AUTHORIZATION

I have been fully informed of the nature of the proposed surgery, the procedures to be utilized, the risks and benefits, alterative treatment available, and the necessity for follow-up and self-care. I understand English or have had someone translate the meaning of this document to me. I am not under the influence of alcohol or other mind-altering substances. I have had an opportunity to ask my questions and discuss my concerns with my doctor to my satisfaction. I request and authorize this treatment for myself. I fully understand that during and following the contemplated procedure, surgery or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE

Patient Name (please print):_____

Patient Signature:_____Date:_____

Doctor Signature:_____Date:_____

Witness Signature:_____Date:_____