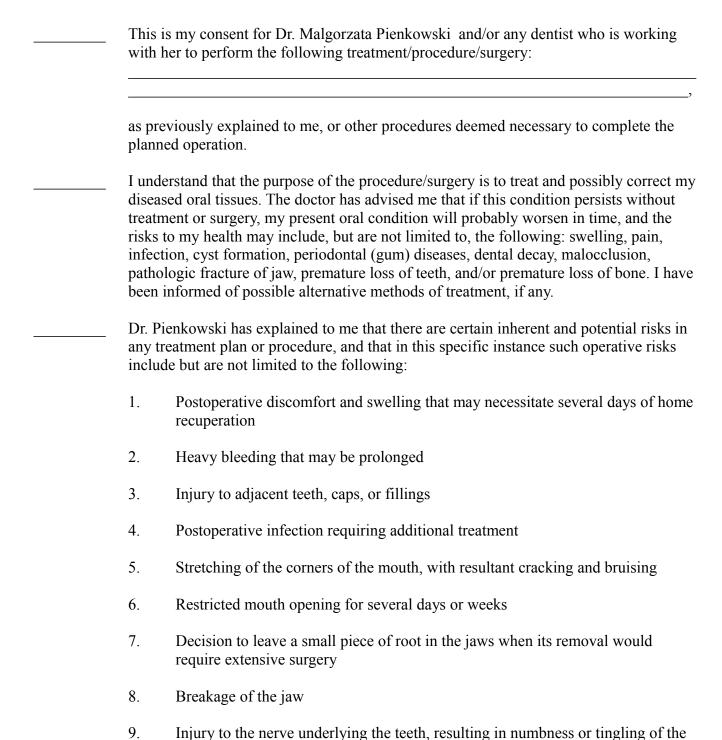
## Informed Consent for Oral Surgery



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

for several weeks, months, or in remote instances, permanently.

lip, chin, gums, cheek, teeth, and/or tongue on the operated side; this may persist

11. Other:		
awareness and coord thus I have been advice while taking same. I understand a 24 hours after my re anesthetic medication for my care. I agree	anesthetics, and prescriptions may causidination, which can be increased by the vised not to work or operate any vehicle medications and/or drugs, or until fully and agree not to operate any vehicle or belease from surgery or until further recoon and drugs that may have been given not to drive myself home after surgery company me home after my discharge	e use of alcohol or other drugs; e, automobile, or hazardous recovered from the effects of hazardous device for at least evered from the effects of the to me in the office or hospital and will have a responsible
doctor's judgment o	ondition should arise in the course of the for procedures in addition to or differencest and authorize the doctor to do what	ent from those now
curative and/or succ differences, there ex my present conditio	urance has been given to me that the processful to my complete satisfaction. Beckists a risk of failure, relapse, selective in despite the care provided. However, it elpful and that a worsening of my conditional treatment.	retreatment, or worsening of t is the doctor's opinion that
	tunity to discuss with the surgeon my mas problems and/or injuries.	nedical and health history,
	completely with the recommendations realizing that any lack of same could res	
UNDERSTAND TH THE OPERATION THAT ALL BLANK COMPLETION WE	HAVE HAD AN OPPORTUNITY TO HE TERMS AND WORDS WITHIN TH AND THE EXPLANATION REFERRI KS OR STATEMENTS REQUIRING IN ERE FILLED IN AND INAPPLICABL BEFORE I SIGNED. I ALSO STATE	HE ABOVE CONSENT TO ED TO OR MADE, AND NSERTION OR E PARAGRAPHS, IF ANY,
Patient, Parent, or Guardian Printed	Patient, Parent, or Guardian Signature	Date
Witness	Doctor	Date