Informed Consent for Oral Surgery

_____ This is my consent for Dr. Malgorzata Pienkowski and/or any dentist who is working with her to perform the following treatment/procedure/surgery:

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_____,

as previously explained to me, or other procedures deemed necessary to complete the planned operation.

_____ I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably 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, dental decay, malocclusion, pathologic fracture of jaw, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

_____ Dr. Pienkowski 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 the following:

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, caps, or 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 jaws when its removal would require extensive surgery
8. Breakage of the jaw
9. Injury to the nerve underlying the teeth, resulting in numbness or 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. Other: _____

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_____ 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 work or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs, or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least 24 hours after my release from surgery or until further 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 surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

_____ 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 (s)he may deem advisable.

_____ No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Because of individual patient differences, there exists a risk of failure, relapse, selective retreatment, 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 the surgeon my medical and health history, including any serious problems and/or injuries.

_____ I agree to cooperate completely with the recommendations of Dr. Pienkowski while I am under her care, realizing that any lack of same could result in a less-than-optimal result.

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

_____	_____	_____
Patient, Parent, or Guardian Printed	Patient, Parent, or Guardian Signature	Date
_____	_____	_____
Witness	Doctor	Date