Smiles Of Carpentersville
27 S Western Ave, Suite E, Carpentersville, IL 60110
Ph. 847-783-6544

Informed consent for Oral Surgery

_____ _____
Patient's Name (PLEASE PRINT) *Date*

I hereby authorize the doctor to perform the following procedures:
_____

The doctor and/or staff have explained to me the proposed treatment and the anticipated results of such treatment. I understand that this is an elective procedure and that there are other forms of treatment available, including the option of no treatment.

The doctor has explained to me that there are potential risks in the treatment plan or procedure. These include:

1. Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue to the operated side. This may persist for several weeks, months or in remote instances, permanently.
2. Postoperative infection requiring additional treatment.
3. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.\
4. Restricted mouth opening for several days or weeks, with possible dislocation of the tempomandibular (jaw) joint.\
5. Injury to adjacent teeth and fillings.
6. In rare circumstances, cardiac arrest or breakage of the jaw.
7. Postoperative discomfort, swelling and bleeding that may necessitate several days of recuperation.
8. Decision to leave a small piece of root in the jaw when its removal requires extensive surgery.
9. Stretching of the corners of the mouth with resultant cracking and bruising.

Unforeseen conditions may arise during the procedure that require a different procedure than as set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary.

I understand that the medications, drugs, anesthetic and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile or hazardous devices while taking such medications and until fully recovered from their effects. I have also been advised not to smoke for two weeks after the surgery.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

_____ _____
Patient's or Guardian's Signature Date