NEW TOWN DENTAL

INFORMED CONSENT
ORAL SURGERY / TOOTH EXTRACTION

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there may be other forms of treatment available, including: root canal therapy, restoration with filling material, restoration with crown, periodontal therapy, or no treatment.

The doctor has explained to me that there are certain potential risks in this 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 on the operated side; this can persist for several weeks, months or, in rare 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 temporomandibular (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. A small piece of root left in the jaw when removal would require 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 set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgement, they are deemed necessary. I understand that the medications, drugs, anesthetics 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 at the same time 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.
It has been explained to me and I understand that a perfect result is not guaranteed or warrantied.

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the nature and purpose of the oral surgery/extraction and have received answers to my satisfaction. I voluntarily assume any and all known possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning my recovery and results of the treatment. The fee(s) for this service have been explained to me and are acceptable.
By signing this form, I am freely giving my consent to allow and authorize
Dr. Snydman and/or his associates to render any treatment necessary or advisable for my dental conditions, including any and all anesthetics and/or medications.

_____ I understand this treatment can also be performed by an Oral Surgeon.
Patient's Initials

Tooth Number(s):_____

_____
Patient's Name (please print)

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Signature of Treating Dentist Date

_____ _____
Witness to signature Date