ARDENT DENTAL
in Lynn Valley

CONSENT FOR ORAL SURGERY

I, <<Patient First Name>> <<Patient Last Name>> hereby authorize Dr.______ to provide the following

procedure: extract tooth number ____.

ALLERGIES: ____

DAILY MEDICATIONS: ____

The Doctor has explained to me the proposed treatment and anticipated outcome. I have agreed to this procedure. I understand that there are other forms of treatment available including no treatment. The doctor has explained to me that there are certain potential risks associated with this treatment plan or procedure. These are unlikely but include:

1. Injury to a nerve resulting in numbness to tingling of the chin, lip, cheek, gums and/or tongue.
2. Post operative infection requiring further treatment.
3. Opening of the sinus (a normal cavity above the upper teeth), may require additional surgery.
4. Restricted opening of the mouth for several days or weeks. Dislocation of the jaw joint is possible.
5. Damage to adjacent teeth, fillings and/or crowns.
6. Post operative discomfort, swelling and bleeding that may necessitate several days of recuperation.
7. Decision to leave a small portion of the tooth.
8. Stretching of the corners of the mouth with resultant cracking and bruising.

Unforeseen conditions may arise during the procedure than set forth above. I therefore authorize the Doctor and any associate to perform whatever procedures they deem necessary with their professional judgment. I understand that some medications, anesthetics and prescriptions that may be taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that with certain medications I cannot consume alcohol or recreational drugs because they can alter the effects of these medications. I am aware that with certain medications it is not advised to operate a vehicle while taking such medications or until I have recovered from their effects.

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Signature of Patient Name or Guardian

<<Date>> Was Pre-Med Taken YES NO

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