



CONSENT FOR SURGICAL TEETH REMOVAL

Dear patient:

You have a right to be informed about your diagnosis and planned surgery so that you may make a decision whether to undergo the procedure after knowing the risks and hazards. This disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

____ 1. This is my consent for Dr. Queresby to perform the following treatment / procedure / surgery:

SURGICAL REMOVAL OF TEETH #: _____

____ 2. The condition has been explained to me as: **dental decay (caries); non-restorable ; abnormal size/form ; orthodontic crowding ; infection/abscess ; acute/chronic periodontitis**

POSSIBLE COMPLICATIONS TO ALL SURGERIES OR SURGICAL REMOVAL OF TEETH:

____ 3. **SWELLING, BRUISING AND PAIN:**

These can occur with any surgery and vary from patient to patient, and from one surgery to another.

____ 4. **INFECTION:**

This is possible with any surgical procedure and may require further surgery and/or medications if it does occur.

____ 5. **TRISMUS:**

This is limited opening of the jaws due to inflammation and/or swelling of the facial muscles. This is most common with impacted tooth removal but it is possible with almost any oral surgical procedure.

____ 6. **DRUG REACTIONS:**

A reaction is possible to any medication given and could include side effects such as nausea, rash, shock and/or death.

____ 7. **BLEEDING:**

Although significant bleeding can occur during or after surgery, it is not common. Some bleeding is, however, usual for most surgeries and is normally controlled by following the post-operative instructions.

____ 8. **TMJ DYSFUNCTION:**

This means the jaw joint (TMJ – temporomandibular joint) may not function properly, and although rare, may require additional treatment, including using heat and rest, to wearing of an oral bite splint, or further surgery. A pop or click in the jaw may develop or an existing pop may worsen.

____ 9. **NUMBNESS:**

Due to the proximity of the tooth roots to the nerve (especially wisdom teeth), it is possible to bruise or damage the nerve during tooth removal. This could be temporary (days, weeks) or very rarely, permanently. The lip, chin, teeth, and/or tongue could feel numb, tingling or have a burning and/or altered taste sensation.

____ 10. **DRY SOCKET INFLAMMATION / INFECTION (ALVEOLITIS):**

This is significant pain in the jaw and ear due to the loss of the blood clot. It most commonly occurs after the removal of wisdom teeth, but is possible with any extraction. It is known to occur higher in persons that **smoke**. This may require medicated socket dressings and additional office visits to treat.

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____ 11. **DAMAGE TO OTHER FILLINGS AND/OR TEETH:**

Due to the close proximity of teeth, possible damage to other teeth and/or fillings can occur when teeth are removed.

____ 12. **INCOMPLETE REMOVAL OF TOOTH FRAGMENTS:**

There are times the doctor may decide to leave in a tooth fragment or root in order to avoid doing damage to special nearby structures, such as nerves, sinuses, etc.

____ 13. **SINUS INVOLVEMENT:**

Due to the location of the roots (especially the upper back teeth) to the sinuses, it is possible an opening may develop from the sinus to the mouth or that a root may be displaced into the sinus. A possible sinus infection and/or permanent opening from the mouth to the sinus could develop, and may require additional medications and/or later corrective surgery.

____ 14. **SHARP RIDGES OR BONE SPLINTERS:**

Occasionally, after an extraction, the edge of the tooth socket can be sharp, or a bone splinter can come out through the gum tissues. This may require another surgery to smooth or remove the bone splinter.

____ 15. **BIRTH CONTROL PILLS:**

I understand that any antibiotic prescribed will interfere with the action of birth control pills.

____ 16. Medications, drugs, anesthetics, and prescriptions may cause **drowsiness** and lack of awareness and coordination, which can be worsened by the use of alcohol or other drugs. Thus I have been advised not to operate any vehicle, automobile or hazardous devices, or to return to work while taking such medications, or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four (24) hours after my release from surgery or until further recovered from the effects of the anesthetic medications and drugs that may have been given to me in the office or hospital. If sedative drugs have been given to me during surgery, I agree not to drive myself home after surgery, and will have a responsible adult drive me and accompany me home after my discharge from surgery.

____ 17. **LOCAL ANESTHESIA:**

Certain possible risks exist that, although uncommon or rare, could include pain, swelling, bruising, infection, nerve damage, allergic reactions which could result in heart attack, stroke, brain damage and/or death.

____ 18. **GENERAL ANESTHESIA:**

I agree and understand that I am not to have and/or have had anything to eat or drink for **6 hours** before my surgery.

____ 19. **GENERAL ANESTHESIA:**

Certain possible risks exist that although uncommon, could include nausea, pain, swelling, inflammation and/or bruising at the injection site. Rare complications could include nerve damage to the arm, allergic or drug reactions, pneumonia, heart rhythm irregularities, heart attack, stroke, brain damage, and/or death.

____ 20. **I have had the opportunity to discuss with Dr. Quereshy my past medical and health history including any significant problems and/or injuries.**

____ 21. OTHER _____

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*Oral & Maxillofacial Surgery
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FAISAL A. QUERESHY, MD, DDS, FACS, INC.
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I CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT AND THE EXPLANATION MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN, AND ANY INAPPLICABLE PARAGRAPHS WERE STRICKEN BEFORE I SIGNED. I ALSO STATE I SPEAK, READ AND WRITE ENGLISH.

Patient / Legal Guardian Signature Relationship to Patient Date

Witness Signature Date

Physician Signature Date

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