GARDEN STATE
ORAL SURGERY GROUP
gardenstateos.com

GENERAL CONSENT FOR SURGERY

This is consent for a dentist employed by **Garden State Oral Surgery Group, Bayonne Oral Surgery, or Oral & Maxillofacial Surgery Institute**, to perform the oral and maxillofacial surgery indicated on my examination chart as explained to me, and any other procedure deemed necessary or advisable as a result of the planned operation. I also agree to the use of local, IV sedation and/or general anesthesia depending on the judgment of the dentist(s)· involved in my care. I have been. informed and understand that occasionally there are complications from the ·surgery, drugs and/or anesthesia. These complications include but are not inclusive of pain, infection, bleeding, swelling; discoloration of the skin, numbness, and tingling· of the lips, tongue, chin, gums, cheeks, and teeth which may persist for days, weeks, months or in some instances permanently. There may be injury to adjacent teeth and/or tissues, referred pain to the ears, neck and head, bone fractures, sinus complications and nasal antral fistulas or openings, which may require further treatment There may be nausea, vomiting, allergic reactions, and/or death from the anesthesia. At the injection site, there can be pain, bruising, numbness and/or inflammation of the vein.

It has been explained to me that during the course of surgery, unforeseen conditions may be revealed which necessitate extension of the original procedure or a different procedure from which was planned. In rare cases, it may not be possible to continue with the procedure. I authorize my doctor and his staff to perform such procedures that are necessary and desirable in the exercise of professional judgment.

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination; thus, I was advised not to operate any vehicle or hazardous device for at least the balance of the present day or until fully recovered from the effects of the medications, drugs, anesthetics, and prescriptions that may have been given for my care in the office or for at home.

I acknowledge the receipt of and understand the post-operative instructions and have been given an appointment to return. The surgery has been explained to me and I understand there is no warranty or guarantee as to the result and/or cure from surgery. I understand that I can ask for a full recital of all possible risks attendant to phases of my care by just asking.

Signature _____ Date _____

ASSIGNMENT OF BENEFITS / GUARANTEE TO COOPERATE / GUARANTEE TO PAY

In consideration of dental treatment to be rendered to me or my dependent, I agree, authorize, assign, and direct payment of insurance benefits to **Garden State Oral Surgery Group, Bayonne Oral Surgery, or Oral & Maxillofacial Surgery Institute** for monies due on my pill, which relates to services rendered. I agree to sign over every dental/medical payment issued to me for services performed by this office within ten business days after receipt from any and all dental/medical corporations/organizations. If the amount owed to this office is less than the amount of the dental/medical payment, then only the balance owed shall be paid I assign to the above dental office the right to prosecute claim(s) against the insurance carrier who affords benefits, and I agree to fully cooperate with this dental provider's efforts to prosecute a claim against the insurance carrier if there is no timely payment of the claim.

I acknowledge full financial responsibility for services rendered by an -employee of **Garden State Oral Surgery Group, Bayonne Oral Surgery, or Oral & Maxillofacial Surgery Institute**. I understand that if my insurance does not pay the fees I incur, I will be fully responsible for them. I agree to pay all reasonable attorney fees and collection costs in the event of default of this payment agreement.

Signature _____ Date _____

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