GARDEN STATE
ORAL SURGERY GROUP
gardenstateos.com

CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY

Patient's Name:____ Date:____

You have the right to be informed about your condition and the recommended treatment plan so tha±'you can make an informed decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you but is rather an effort to provide information so that you may give or withhold your consent.

____ **1.** My condition has been explained to me as:
Gross Decay / Carious Lesion/ Pericornitis / Malposed Mucocele/ Fibroma ____

____ **2.** The procedure(s) necessary to treat the condition(s) has/have been explained to me and I understand the nature of the treatment to be: ____

____ **3.** I have been informed of possible alternate methods of treatment (if any), including: **none**
I understand that these other forms of treatment or no treatment at all, are choices that I have and the risks of those choices have been presented to me.

____ **4.** My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment and in this specific instance they include, but are not limited to:

a. Post-operative discomfort and swelling that may require several days of at-home recovery.
b. Prolonged or heavy bleeding that may require additional treatment.
c. Injury or damage to adjacent teeth or fillings.
d. Post-operative infection that may require additional treatment.
e. Stretching of the corners of the mouth that may cause cracking or bruising, may heal slowly.
f. Restricted mouth opening during healing, sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (1MJ), especially when TMJ problems already exist.
g. A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
h. Fracture of the jaw (usually only in more complicated extractions or surgery).
i. Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling, or other sensory disturbances in the chin, lip, cheek, gum, or tongue and which may persist for several weeks, months, or in rare instances, permanently.
j. Opening of the sinus (a normal chamber situated above the upper teeth) requiring additional surgery or treatment.
k. Dry socket (loss of blood clot from the extraction site).
l. Allergic reaction (previously unknown) to any medications used in treatment.

____ **5.** It has been explained that during the course of treatment, unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph 2 above. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are medically necessary and desirable to complete my surgery.

____ **6.** **ANESTHESIA**
The anesthetic prescribed for my surgery is:

- ☐ Local Anesthesia
- ☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
- ☐ Local Anesthesia with Oral Premedication
- ☐ Local Anesthesia with Intravenous Sedation

Bayonne Oral Surgery
925 Broadway
Bayonne, NJ 07002
(201) 858-1400
bayonne@gardenstateos.com

Oral & Maxillofacial Surgery Institute
67-73 Fillmore St
Newark, NJ 07105
(973) 643-1130
newark@gardenstateos.com

____**7.** **ANESTHETIC RISKS** include discomfort, swelling, bruising, infection, prolonged or/and permanent numbness, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis), which may cause prolonged discomfort and or disability and may require special canine. Nausea and vomiting, although, uncommon. may be unfortunate side effects_ of IV anesthesia. Intravenous anesthesia is a serious medical procedure and although considered safe, does carry with it the rare risk of heart irregularities, heart attack, stroke, brain damage, or even death.

____**8.** **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**
Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to accompany you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours. During your recovery time (first 24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

____**9.** You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO DRINK FOR 8 HOURS PRIOR TO ANSESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, using only a small sip of water.

____**10.** It has been explained to me, I fully understand that a perfect result is not or cannot be guaranteed.

Information for Female Patients

____**11.** I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician. that I can return to the use of oral birth control pills.

Photography

____**12.** I consent to photographs, videos, and digital images being taken before, during and after the procedure to be performed, to evaluate procedure effectiveness, for medical/dental, scientific, or educational purposes, training, professional publications, or marketing/sales purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly without my consent.

____**13.** I acknowledge full financial responsibility for services performed by an employee of Bayonne Oral Surgery. 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.

Consent

I certify that I have read and fully understand this consent for Surgery, have had my questions answered and that all blanks were filled in prior to my initials or signature.

______________________________ ______________________________
Patient (Parent or Legal Guardian if the patient is a minor) Date

______________________________ ______________________________
Doctor's Signature Date

______________________________ ______________________________
Witness Signature Date