CASTLE PEAK
DENTAL

Surgical Consent Form

Patient Name: _____ Date: _____

Procedure(s) Recommended: Extraction(s)____Bone Graft(s)____ Membrane___ Check all that apply
Teeth#_____ Dentist:_____

- I have been informed that this is an elective procedure and that the alternative methods of treatment (if any) or no treatment at all are the choices that I have.
- It has been explained to me that there are certain inherent and potential risks in any treatment procedure. The more common operative risks include, but are not limited to;
    a. Post-operative bleeding that may require treatment and/ or bruising
    b. Delayed healing or dry socket that may require post-operative care
    c. Stretching of the corners of the mouth may occur with resultant cracking or bruising
    d. Damage to adjacent teeth or fillings, Post-operative infection
    e. Possible involvement of the sinus during removal of upper molars which may require additional treatment or surgical repair at a later date
    f. Drug reactions and side effects such as nausea, vomiting, or an allergic reaction
    g. Possible involvement of the nerve within the lower jaw during the removal of lower molars resulting in temporary (but possibly permanent) tingling or numbness of the lower lip, chin, or tongue on the operated side.
    h. Bone fractures and/ or root fragments may break and be left in the jaw
- Bone loss can occur during the extraction and will occur over time unless bone grafting is done at the time of the extraction. An implant also needs to be placed in 6 months or bone loss with begin to occur, leading to the possible inability to have implant in the future without more extensive bone augmentation procedures needed.
    a. The need for additional or more extensive bone grafting in the future to obtain sufficient bone.
    b. Rejection of some of the coronal portions of bone particles for some time after the procedure or rejection of the entire bone graft
    c. During the course of the procedure(s), unforeseen conditions may be revealed that necessitate changing the treatment plan discussed in the paragraph above. I therefore authorize and request that the doctor perform such procedures as are necessary and desirable in the exercise of professional judgment.
- Medications, drugs, anesthetics, and prescriptions all have the potential to cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol and other drugs. I understand that pain medication may also cause drowsiness, lack of awareness, and problems of coordination.
- It has been explained to me, and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.
- I certify that I have read and fully understood this consent for surgery. Please ask the doctor if you have any questions concerning this consent form.

_____ _____
Signature Date

_____ _____
Witness Date