Oral Surgery/Anesthesia Consent Tooth # _____

I _____, understand and consent to as indicated on the oral surgery record and to any other surgery deemed necessary (or advisable) in addition to the planned surgery. The procedure(s) to be performed have been thoroughly explained to me.

I have been informed and understand that occasionally there are complications with surgery, drug(s) and/or anesthesia. The most common complications are pain, infection, swelling, bleeding, bruising, discolouration, temporary or permanent numbness and tingling of the lip, tongue, chin, gum, cheek and/or teeth. Further, I understand that pain and numbness, occasionally inflammation of the vein (thrombophlebitis) may occur from the intravenous or intramuscular injection. The possibility of injury to (or stiffness of) the neck and facial muscles, changes in the occlusion or this temporomandibular joint have been explained. I understand that there is the possibility of injury to the tissues, referred pain to the ear, neck, head, and nausea; vomiting, allergic reaction; bone fractures and/or delayed healing. Sinus complication may include nasal fistula or an opening into the sinus from the mouth as a result of the removal or surgery of the upper teeth. Jaw or tuberosity fracture are possible complications of teeth extraction. Adjacent teeth and restorations can sometimes be damaged during an extraction.

In addition, in giving my consent, I am agreeing to the use of local sedation or general anesthesia depending on the judgment of Dr._____. In the event of an emergency, please contact us immediately at 403-262-2627.

All of my questions have been answered to my satisfaction.

Patient's Signature:_____ Date: _____

Witness: _____ Date: _____