ALABAMA FAMILY DENTISTRY

PERMISSION TO ADMINISTER LOCAL ANESTHETIC & ANTIBIOTICS

CONSENT FOR SURGICAL PROCEDURES

Patient Name:______________________________ **Date:**_________________________

State law provides that you have the right to informed about the procedures, surgery, and treatment to be provided by your dentist and you are required to decide whether to accept the proposed surgery and/or treatment. This also includes any anesthetics that you may be subjected to. Because of this legal requirement and because well-informed patients are a great aid to successful treatment, the following information is provided for your approval and acknowledgement of your consent to the procedure and treatment.

I,_________________________,hereby authorize and direct Dr.____________________and/or they may select such associates or assistants as to perform upon the above listed patient.

I have been informed of the nature of the procedures, along with risks, complications, and side effects. I hereby consent to accept these risks, complications, side effects, and any necessary additional treatment, which I understand may include, but are not limited to:

1. Swelling, bruising, nausea, or vomitting;
2. Tingling or numbness of the lips, tongue, gums, chin and/or cheeks due to nerve injury;
3. Loss or damage to other teeth or restorations (fillings);
4. Roots or teeth displaced into the sinus, oral antral fistula, and maxillary sinusitis;
5. Possible jaw fracture;
6. Post-operative discomfort, bleeding, infection, or dry sockets;
7. Temporomandibular joint (TMJ) pain and/or dysfunction.

I understand that the practice of surgery is not an exact science and acknowledge that no warranties or guarantees of any kind have been made to me by anyone concerning the results of this procedure or treatment.

I understand I cannot drive a motor vehicle for 12 hours after receiving any form of sedation or general anesthetic and while on any post-operative medication I should also refrain from driving. I hereby certify that I understand all of the information in this consent form, as well as additional information conveyed orally to me by Dr.____________________or their assistants and/or associates, which is not necessarily set forth in this form and having considered the expected risk and possible side effects and complications associated to the proposed surgical procedure or treatment, I hereby consent to the procedures and treatment described above in this form.

ANTIBIOTICS: I will inform the Doctor of any allergies I have related to antibiotics or other drugs. I also understand certain antibiotics may interfere with birth control pills and extra contraceptive methods should be used while taking antibiotics. Consult your physician and pharmacy.

BE SURE YOU HAVE READ THIS CONSENT. IF YOU DO NOT UNDERSTAND ANY PART OF IT, ASK TO HAVE IT EXPLAINED TO YOU.

Signed:_________________________________ Date:_________________________

Patient

_________________________________ Witness:_________________________

Parent/Guardian if minor