ABINGTON FAMILY DENTAL CARE

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477 Washington St.
Abington, MA 02351

ORAL SURGERY CONSENT FORM

Patient Name: _____ Date: _____

I hereby authorize Abington Family Dental Care and any associates to perform the following procedures:_____ STOP & READ BELOW

The doctor and or staff have explained to me the anticipated results of the surgical procedure as well as the estimated financial obligation. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment. The doctor has explained to me that there are certain potential risks in the treatment plan or procedure. These include:

1. Injury to a nerve resulting in numbness or tingling of the chin, lips, cheek, gums, and or tongue to the operated side. This may persist for several weeks, months, or in remote instances, permanently. _____
2. Postoperative infection requiring additional treatment. _____
3. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery. _____
4. Restricted mouth opening for several days or weeks, with possible dislocation of the tempromandiubular (jaw) joint. _____
5. Injury to adjacent teeth and fillings. _____
6. In rare circumstances, cardiac arrest or breakage of the jaw. _____
7. Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation. _____
8. Decision to leave a small piece of root in the jaw when its removal requires extensive surgery. _____
9. Stretching of the corners of the mouth with resultant cracking and bruising. _____

Unforeseen conditions may arise during the procedure that requires a different procedure than as set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary.

I understand that the medications, drugs, anesthetic, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they may increase these effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects. **I have also been advised not to smoke for two weeks after the surgery.** _____

Are you presently taking medication for Osteoporosis _____ Blood Thinner _____

Patient (Parent/Guardian if under 18) Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____