PRINT

Abby DENTALCARE

Consent for Oral Surgery

Patients Name _____ Date: _____

I, the undersigned, consent to the following oral surgery procedure:

Extraction of tooth #(s) _____
OR
Oral Surgery Procedure _____

I have been advised to the alternative treatment to this procedure. The specific risks and complications of the procedure have been explained and questions have been answered to my satisfaction.
Specific surgical risks or complications include:

- Postoperative swelling, bleeding or bruising
- Postoperative pain
- Postoperative infection, including dry socket
- Limitation of mouth opening
- Damage to adjacent teeth appliances
- Temporary or permanent injury to nerves providing sensation to the lips, face and tongue (lower teeth)
- Sinus infection or opening into the mouth (upper teeth)

I also consent to the administration of local anaesthetic as deemed necessary by the treating dentist. Dr. T. Bevans ***or*** Dr. B. Burrows (please circle)

Signature: _____

Patient/Parent/ Guardian Signature: _____

Witness Signature: _____