

CONSENT FOR OPERATION

This is my consent for Dr. Taylor, Dr. Hou, Dr. Lee , and/or associates to perform the oral surgery and anesthetics as indicated on the examination and surgery record sheet and any other oral surgery procedure deemed necessary or advisable as a corollary to the planned operation. I also agree to the use of a local or general anesthetic and premedication or sedation by the intravenous, inhalation, intramuscular or oral route, depending upon the judgment of the dentist(s) involved in my case. I understand that occasionally there are complications associated with surgery and/or the administration of anesthetics. I understand the possible hazards and possible complications in connection with these procedures including but not limited to:

1. Postoperative pain, swelling, bleeding (which may produce discoloration of the skin), or infection
2. Loss of feeling, tingling, pain (both temporary or permanent) of the tongue, lip or chin, especially following removal of mandibular (lower) teeth.
3. Phlebitis of a vein used to administer medications may occur which may result in pain, numbness or irritation.
4. Stiffness of facial muscles and change in the bite or temporomandibular joint syndrome. (chronic pain or dysfunction of a "jaw joint")
5. Injury to the adjacent teeth or restorations in adjacent teeth or injury to other tissues not within the described surgical area.
6. Referred pain to neck and ear.
7. Unfavorable reaction to drugs and anesthetics such as nausea or allergy, or even death in rare cases.
8. Sinus complications resulting from the removal of, or surgery on the maxillary (upper) teeth, including infection or an opening into the sinus which might require a secondary surgery to close.
9. Possible fracture of the mandible when associated with the removal of lower molar teeth, or during the immediate post-operative period.
10. Apicoectomies (surgical root canals) may not be successful and may become infected or the tooth may be lost despite all treatment; also this procedure on a lower tooth may produce permanent lip numbness.

I have been informed of all possible hazards and complications of the surgery and anesthesia and other drugs. I should not operate any vehicle or hazardous devices until I am fully recovered from my anesthetic or when taking narcotic medications.

The fee for these services has been explained to me and is satisfactory.

The nature of the surgery and anesthesia has been FULLY EXPLAINED TO ME, including alternatives of treatment, and no warranty or guarantee has been made as to the results or cure. I also agree to accept the opinion of the American Council of Arbitration on any dispute against the doctors arising out of the treatment furnished.

\_\_\_\_\_  
SIGNATURE (patient, or parent if minor)

\_\_\_\_\_  
Date

When the patient is a minor or incompetent to give consent, signature should be of person authorized to consent for the patient.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Doctor

\_\_\_\_\_  
Date