Cherry Orchard
ORAL & IMPLANT SURGERY

Patient Name: _____

INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA

This is my consent form for Dr. Brian R. Cherry to perform the following treatment of the designated diagnosis:

_____

_____.

was explained to me, or any other procedure deemed necessary or advisable to complete the planned operation. I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral/maxillofacial tissues.

The doctor has explained to me that there are certain inherent and potential risks including but not limited to:

_____ Postoperative discomfort and swelling that may necessitate several days of home recuperation.

_____ Heavy bleeding that may be prolonged.

_____ Injury to adjacent teeth and fillings.

_____ Postoperative infection requiring additional treatment.

_____ Stretching of the corners of the mouth with resultant cracking and possible bruising.

_____ Restricted mouth opening lasting several days or weeks. This may occur in a pre-existing TMJ disease in which treatment may exacerbate an underlying TMJ condition and make it worse.

_____ A decision to leave a small piece of root in the jaw, when during removal, would require extensive surgery or damage to adjacent structures.

_____ In rare instances, breakage of the jaw is a risk factor.

_____ Injury to the nerve underlying the teeth resulting in numbness of the lip, chin, gums, cheek, teeth, or tongue on the operated side. This may persist for several weeks, months, or in remote instances, permanently.

_____ Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

_____ Dry socket (A loss of a natural blood clot in the socket causing pain).

_____ I have been made aware of Bisphosphonate related osteonecrosis of the jaws (chronic bone infection).

_____ Sharp ridges or bone splinters may develop following surgery that may require a follow up visit to remove.

_____ Antibiotics (and other medicines) may interfere with birth control efficacy. Alternative means of birth control should be considered in the event these medicines are prescribed.

_____ I consent to administration of such local and/or general anesthesia, sedation, and analgesia as deemed necessary for Dr. Brian R. Cherry to accomplish the proposed procedures.

_____ I understand I must have an escort bring me to the office, **STAY** during the procedure, and take me home or my surgery cannot be accomplished.

_____ Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus I have been advised not to operate any vehicle, automobile or hazardous devices, or work while taking such medications and/or drugs, or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after my discharge from surgery.

_____ I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires a general anesthetic or sedation.

_____I agree and understand that I am not to have **anything to eat or drink (to include <u>water or any other liquids</u>) for at least 8 hours before** my oral surgery. General anesthesia cannot be administered unless this is the case.

_____ No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

_____ I have had an opportunity to discuss with Dr. Brian R. Cherry, my past medical history and fully disclosed all medications that I am presently taking; all allergies to drugs and foods; any serious problems, and/or injuries.

_____ I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT.

_____	_____
Patient, Parent, or Guardian	Date
_____	_____
Dr. Brian R. Cherry, DMD	Date
_____	_____
Witness	Date

Brian R. Cherry, DMD *Board Certified Oral and Maxillofacial Surgeon*

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