SURGICAL EXPOSURE AND/OR BRACKETING OF IMPACTED TEETH INFORMED CONSENT

______________________________________ _________________________

Patient's Name Date of Birth

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all of the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Diagnosis: ____

Procedure: ____

Alternative options: ____

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1. I have been informed of and understand the potential risks related to this surgical procedure include but are not limited to:

• Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth.

• Nerve injury, which may occur from the surgical procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;

• The applied bracket may come off and need to be re-attached. The bracket, wire and /or fine chain attached to the braces to pull the tooth into position may cause irritation to the tongue, lips, or cheek areas;

• The impacted tooth might not move and may be left in place or may need to be removed;

• An opening may occur from the mouth into the nasal or sinus cavities.

• Periodontal (gum) problems associated to the tooth having received the traction.

2. I have been informed of and understand that follow up visits or care, additional evaluation, treatment or surgery may be needed.

3. Patient's Responsibilities

I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I understand the use of tobacco and alcohol is detrimental to the success of my treatment.
I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any postoperative problems as they arise. My failure to comply could result in complications or less than optimal results.
I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.
If I am sedated during the procedure, I further authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

_____________________________________ _____________

Patient or Legal Representative Signature Date

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

_______________________________ _____________

Doctor Signature Date Date