dentalarts
DAVIS SQUARE

Surgical Consent Form

Patient First Name _____

Patient Middle Initial _____

Patient Last Name _____

I give permission to perform the following procedure:

_____

Diagnosis:

_____

☐ I hereby certify that I fully understand this surgical treatment and the reasons why it is necessary. I have been given the opportunity to ask questions and have been given satisfactory answers.

I consent for the procedure(s) to be done with the following anesthesia and/or medications:
☐ Local Anesthesia ☐ Local Anesthesia with Nitrous Oxide and Oxygen

When did you last eat/ drink? What did you have?

_____ _____

I also understand that the administration of medications and performance of surgery carry certain common inherent risks, such as, but not limited to:

- Drug reactions and side effects
- Post-operatory bleeding
- Post-operatory infection or bone inflammation
- Possible involvement of the sinus of the upper jaw during removal of the upper back teeth, requiring possible surgery for repair at a future date.
- Possible involvement of the nerve within the lower jaw during removal of the lower posterior teeth, resulting in usually temporary, but possible permanent numbness and/or tingling in the lower lip.
- Possible fracture of the jaw.
- Bruising and/or vein inflammation at the site of the injections.

I am aware that the practice of Dentistry is not an exact science, and I acknowledge that no guarantees have been made to me as a result of the procedures authorized above.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

Witness Signature _____ Date _____