# INFORMED CONSENT TO PERFORM ORAL SURGERY

**NOTE: To prevent excessive bleeding, avoid taking the following medication prior to surgery. If your doctor prescribed any of these, we will need to make special arrangements to prepare for your treatment.**

Refrain from:
Aspirin – for at least 2 WEEKS; Baby Aspirin – for at least 1 WEEK.
Coumadin for at least 5 DAYS.
Vitamin E 800mg – for at least 2 WEEKS.
Ibuprofen – for at least 5 DAYS.
Gingko Biloba – for at least 5 DAYS.

Dr. _____ will prescribe your surgical medications as needed.

I, _____, authorize Dr. _____ to perform the following surgical procedure:

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I have been advised as to the consequences if oral surgery is not performed including, but not limited to, pain, infection, swelling, periodontal disease, damage to other teeth, and malocclusion.

I have been advised of the risks involved with the oral surgery procedure including, but not limited to, the following:

1) Bleeding
2) Post-operative infection
3) Post-operative pain and swelling
4) Dry-Socket
5) Root-tip breakage
6) Temporary or Permanent numbness to lips, tongue, oral tissues, or teeth
7) Sinus exposure
8) Damage or sensitivity or adjacent teeth
9) Jaw fracture
10) Temporomandibular Joint (TMJ) dysfunction
11) Residual bone chips

I have read the above statements, and have asked all questions about the procedure to Dr. Pickle or staff. I have also been advised as to alternative treatments including:

1) No treatment _____
2) Other: _____

I consent to the use of local anesthetic being used during the procedure. The risks and benefits of the use of local anesthetic have been explained to me, including but not limited to:

1) Possible allergic reaction
2) Possible increase in blood pressure
3) Possible tolerance
4) Possible temporary or permanent numbness to lips, tongue, oral tissues or teeth
5) Possible tenderness, soreness and bruising at injection site (s)

I have read the Oral Surgery Information Sheet and the Post-Operative Instructions, and understand them. I consent to Dr. _____ and staff to perform the oral procedure indicated for my tooth/teeth.

_____

Signature of Patient (or Guardian)

_____

Signature of Doctor

_____

Signature of Witness

Date and Time: _____