

ASSOCIATED ORAL AND MAXILLOFACIAL SURGEONS OF PEORIA, LTD.

John J. Otten, M.D., D.D.S.

Larry D. Otte, D.M.D.

Nathan D. Schroeder, D.M.D., M.S.

Consent for Oral and Maxillofacial Surgery and Anesthesia

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

I, _____ hereby authorize Dr. _____, his associates and staff to perform upon myself (or upon _____, a minor of which I am the legal guardian or have healthcare power of attorney) the following procedure(s):

and to administer the anesthesia I have chosen, which is:

- local anesthesia
- local with nitrous oxide / oxygen analgesia
- intramuscular sedation (IM) / anesthesia
- intravenous sedation (IV) / anesthesia

- ___ 1. I understand other treatment options include no treatment, root canal treatment, and restorative treatment by a general dentist, which I have declined.
- ___ 2. I understand that certain complications may occur as a result of my surgery which include (but are not limited to): swelling, bruising, stiffness of jaw muscles and jaw joints (TMJ) which may be of short or long duration.
- ___ 3. With tooth extraction, I understand that there may be unexpected damage to adjacent teeth or fillings, sharp ridges or bone splinters that may require later surgery to smooth or remove, dry socket which will require additional care, or small fragments of tooth root which may be left in place to avoid damage to vital structures such as nerves or sinus.
- ___ 4. Lower tooth roots may be very close to the nerve and surgery may result in pain or a numb feeling of the chin, lip, cheek, gums, teeth or tongue lasting for weeks, months, or may rarely be permanent. On upper teeth whose roots are close to the sinus, a sinus infection may develop, a root tip may enter the sinus and/or an opening from the mouth to the sinus may occur which could require later medication or surgery.
- ___ 5. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability, and may require special care.
Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the rare risks of heart attack, stroke, brain damage or death.

___ 6. **YOUR OBLIGATIONS IF IV/IM ANESTHESIA IS USED**

- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are recovered sufficiently to care for yourself. This may be up to 24 hours.
- B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
- C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
- D. **However**, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or medications provided by this office, **using only a small sip of water.**

___ 7. I understand that no guarantee can be promised and I give my free and voluntary consent for treatment. I realize that my doctor may discover conditions requiring different surgery or anesthesia from that which was planned, and I give my permission for those additional procedures and techniques that are advisable in the exercise of professional judgment.

___ 8. In the unlikely event of accidental direct contact with bodily fluids, including blood and saliva, I give my consent for my blood to be drawn for testing to ensure the safety of both patients and staff.

___ 9. **FEMALES ONLY:** To the best of my knowledge, I am currently **NOT** pregnant.

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read and write English.

Patient's (or Legal Guardian's) Signature

Date

Witness' Signature

Date

Doctor's Signature

Date

VISION / READING IMPAIRED:

The above consent was read to me to my satisfaction. My initials here, indicate that I fully understand all material covered, and the risks involved of the proposed surgery and anesthesia.

Patient Initials _____ Employee Initials _____ Date _____