ARI DENTAL OFFICE

CONSENT FOR ORAL SURGERY

Patient's Name_____ **Date** _____

Procedure(s)_____

Dr. Aram Mohajer has explained to me that there are certain inherent and potential risks associated with the above mentioned treatment, procedure or sedation. The risks include yet are not limited to:

1. **Post-operative swelling and discomfort that may require several days of home recuperation.**
2. **Post-operative infection requiring additional treatment.**
3. **Decision to leave a small piece of the root in the jaw when its removal would require more extensive surgery or present risk of injury to adjacent teeth or nerves.**
4. **Restricted mouth opening and jaw stiffness of variable duration.**
5. **Injury to adjacent teeth and fillings which may require additional care.**
6. **Nerve complication resulting in numbness or tingling of the lip, chin, teeth gums, cheek and / or tongue on the operated side. This altered sensation may occur for a variable temporary period of time or in rare cases, may be permanent.**
7. **Exposure of sinuses possibly requiring additional special instructions, care or surgery.**
8. **In the event a bone graft or soft tissue graft is performed to attempt to rebuild lost bone or improve tissue contour, I realize that several substances can be used. These include, but are not limited to my own bone or gum, a transplant from another human, synthetic bone or soft tissue substitutes, or processed bone or tissue from animals.**
9. **If I chose to have Nitrous Oxide and Oxygen analgesia used to relax me, I acknowledge that I have had the effects explained and understand that I will be able to leave and drive under my own power once the gas has been cleared from my system.**

I have read this consent and have been offered a full explanation of its contents. I have been advised not to work for twenty-four hours after surgery and while taking strong painkillers.

I understand this document and hereby give my informed consent for the above mentioned dental treatment.

_____ _____

Patient/Parent/ or Guardian signature **Date**

_____ _____

Doctor's signature **Signature of witness**