

# Informed Consent for Oral & Maxillofacial Surgery

Procedure :

Surgical removal of tooth/teeth #'s \_\_\_\_\_.

Alternatives to Surgery:

I understand that risks to my health if these teeth are not removed include but are not limited to:

- 1) Infection
- 2) Cyst or tumor formation
- 3) Periodontal (gum) disease
- 4) Increased risk for complications if removal is required at a later time.

Possible complications which have been discussed with me include but are not limited to:

- 1) Injury to the nerves, to the lower lip and tongue causing numbness, which could possibly be permanent.
- 2) Bleeding and/or bruising which may be prolonged
- 3) Dry socket
- 4) Involvement of the sinus above upper teeth
- 5) Infection
- 6) Decision to leave a small piece of rot in the jaw when its removal would require extensive surgery and increased risk of complications.
- 7) Injury to adjacent teeth or fillings.
- 8) Unusual reaction to medications given or prescribed.
- 9) \_\_\_\_\_

Anesthesia: I may receive nitrous oxide (laughing gas) in addition to a local anesthetic to make the surgery more comfortable.

I understand that a perfect result cannot be guaranteed. If any unforeseen conditions arise during the procedure, I request and authorize Dr. Wong to do whatever he deems advisable to correct the condition. This may include referring me for further care to an Oral Surgeon specialist for further treatment.

I agree to cooperate completely with Dr. Les Wong and will follow post operative instructions to the best of my ability for my own comfort and safety.

**I have had the opportunity to discuss my surgery with Dr. Les Wong and ask him questions. I consent to the recommended surgery as it has been described to me.**

Patient, Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Dr. Les M. Wong : \_\_\_\_\_ Date: \_\_\_\_\_

Witness : \_\_\_\_\_ Date: \_\_\_\_\_