

INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA

This is my consent for Doctor Maxine Moncrieffe to perform the following treatment(s), procedure(s) or surgeries:

as previously explained to me, or other procedures deemed necessary to complete the planned operation.

I understand that the purpose of the procedure(s)/surgery is to treat and possibly correct my diseased oral/maxilla-facial tissues. The Doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time, and the risks to my health may include, but are not limited to the following: pain, swelling, infection, cyst formation, periodontal (gum) disease, dental carries, mal-occlusion, pathologic jaw fracture and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

Dr. Moncrieffe has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks may include, but not limited to:

1. Post operative discomfort and swelling that may necessitate several days of home recuperation.
 2. Prolonged bleeding.
 3. Injury to adjacent teeth and restorations.
 4. Post operative infection requiring additional treatment.
 5. Cracking and bruising of the corners of the mouth resulting from stretching.
 6. Restricted mouth opening for several days due to soreness and swelling.
 7. Leaving a small piece of root in the jaw as opposed to extensive surgery to remove it.
 8. Jaw Fracture/ Breakage
 9. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months or, in rare instances, permanently.
 10. Opening of the sinus (a normal cavity above the upper teeth) that will require additional surgery.
 11. Other possible complications _____
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Medications, Prescription drugs and anesthetics may cause drowsiness and lack of awareness and coordination, which can be magnified by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle or other devices that require dexterity and coordination while taking such prescribed medications.

Should any unforeseen condition arise during the operation, requiring the Doctor's judgment or for procedure in addition to or different from those planned, I request and authorize the doctor to do whatever she deem advisable.

No guarantee or assurances have been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exist a risk of failure or relapse without the recommended course of treatment.

I have had the opportunity to discuss with Dr. Moncrieffe my past and present medical and health conditions including any major operations and/or prosthetics and any ongoing treatment I may be receiving.

I agree to cooperate completely with the recommendation(s) of Dr. Moncrieffe while under her care, realizing that not doing so may compromise my care.

I certify that I have had the opportunity to read and fully understand the terms and words contained herein and do give my consent.

Name/relationship to patient

Signature

date

Dr. Moncrieffe

Witness

date