Drs. Turner & Butler, DMD, PA
Dba: Croasdaile Dental Arts
2900 Croasdaile Drive, Ste 5
Durham, NC 27705
919-383-7402 office

Statement of Consent for Surgery

The purpose or this Informed Consent Form is to provide an opportunity for patients and/or guardians to understand and give permission for oral surgery. Each item should be initialed after the patient and/or parent or guardian have had the opportunity for discussion and questions. What you are being asked to sign is a confirmation that we discussed the nature of the proposed treatment, the known risks associated with it and the feasible alternative treatments.

I, _____ hereby authorize and request, Croasdaile Dental Arts, his/her partners and/or associates to perform on me the following outlined oral surgery as outlined in the treatment plan (as outlined on the treatment form that has been provided to me).

_____ Extraction of teeth number(s): _____

And in the event of unforeseen circumstances, I consent to the performance of such additional and Alternative procedures as in the judgment of the above doctor(s) may be necessary to preserve my overall Health.

_____ 1. I accept and understand that this oral surgery can be performed under:
- _____ a. local anesthesia/injection
- _____ b. oral sedation
- _____ c. IV sedation

_____2. I accept and understand that I elect to have the above oral surgical procedure under:
- _____ a. local anesthesia
- _____ b. oral sedation
- _____ c. IV sedation

_____4. My doctor has explained to me that there are certain inherent and potential risks and side effects in any surgery Procedure and in this specific instance such risks include, but are not limited to, the following:
- _____ a. Postoperative discomfort and swelling
- _____ b. Prolonged or heavy bleeding that may require additional treatment.
- _____ c. Injury or damage to the adjacent teeth or roots of adjacent teeth.
- _____ d. Postoperative infection that may require additional treatment.
- _____ e. Stretching of the corners of the mouth that may cause cracking and bruising.
- _____ f. Restricted mouth opening for several days; sometimes related to swelling an muscle soreness and sometimes related to stress on the jaw joints (TMJ).
- _____ g. Injury to the nerve branches underlying the teeth resulting in numbness or tingling of the Chin, lips, cheek, gums, tongue, or teeth. This may persist for several weeks, months or, in rare instances permanently.
- _____ h. Opening into the sinus (a normal chamber above the upper back teeth) requiring additional Treatment.
- _____ i. Decision to leave a small piece of tooth in the jaw when removal would require extensive surgery or treatment.
- _____ j. Fracture of the jaw.

_____5. I acknowledge that the alternatives to this treatment have been discussed with me and I understand these

options and the associated consequences.

_____6. If during the procedure, a change in treatment is required, I authorized the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such decision.

This section is only applicable to **IV SEDATION**: (please initial each statement in the space provided)

_____ I consent to the administration of the local and/or intravenous anesthesia as deemed necessary by a representative of Drs. Jordan, Turner, & Butler, DDS, PA to accomplish the proposed procedure. This administration may cause an undesirable reaction or side effects, which may include, but not limited to bruising, cardiac stimulation, temporary or very rarely permanent numbness.

_____ I also certify that if intravenous anesthesia is to be used that I will not have anything to eat or drink 6 hours before my surgery with the exception of prescribed medications. I understand that non-compliance may have serious medical consequences.

_____ I understand that the use of illegal drugs before or after surgery may be life threatening.

_____ I understand that no guarantee of assurance regarding the results of the proposed procedure being curative of successful can be given.

_____I also understand that I have the option to be referred to oral surgeon who specializes in this procedure.

By my signature below, I acknowledge the above information has been read and reviewed with me by a member of the doctors staff. I further acknowledge I have been given the opportunity to ask questions, have them answered satisfactorily and discuss any concerns of all information received. I verify a copy of this consent has been received by me this date and a signed copy has been retained for my patient file.

_____ _____

Patient's Signature Date

_____ _____

Witness Signature Date

_____ _____

Doctor Signature Date

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