Dr. Ronald P. Morris • Oral & Maxillofacial Surgeon

Under the laws of our state, it is our legal and ethical obligation to obtain written informed consent for any procedure contemplated. It is not our intention to scare or frighten you, but only to make you fully aware of the risks and benefits involved.*

INFORMED CONSENT FOR SURGERY AND ANESTHESIA

This is my consent for Dr. Morris and/or any oral and maxillofacial surgeon who is working with him to perform the following treatment/procedure/surgery, as previously explained to me:

_____

_____

Special Instructions _____

_____ or other procedures deemed necessary or advisable to complete the planned operation.

I understand that the purpose of the treatment/procedure/surgery is to treat and possibly correct my diseased oral/maxillofacial 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 not limited to, the following: swelling, pain, infection, cyst formation, periodontal (gum) diseases, dental caries, malocclusion, pathologic fracture of the jaw, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative

_____ methods of treatment, if any.

Dr. Morris 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 include, but are not limited to: (Check applicable items.)

_____ 1. Post-operative discomfort and swelling that may necessitate several days of home recuperation.
_____ 2. Heavy bleeding that may be prolonged.
_____ 3. Injury to adjacent teeth and fillings.
_____ 4. Post-operative infection requiring additional treatment; dry sockets.
_____ 5. Stretching of the corners of the mouth with resultant cracking and bruising.
_____ 6. Restricted mouth opening for several days or weeks.
_____ 7. Decision to~leave a small piece of root in the jaw when its removal would require extensive surgery
_____ 8. Breakage of the jaw.
_____ 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 remote instances, permanently.
_____ 10. Opening of the sinus (a normal cavity situated above the upper teeth), requiring additional surgery.
_____ 11. Other.

I understand that I am not to have anything to eat or drink for six (6) hours before my surgery if having general anesthesia and that I will

_____ bring a responsible adult to stay here and drive me home.

I consent to administration of such local and/or general anesthesia as deemed necessary by Dr. Morris and/or his designated assistants to

_____ accomplish the proposed procedure.

Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle or hazardous device, or to work, while taking such medications and/or drugs, or until fully recovered from the effects of the same. I agree not to operate any vehicle or hazardous device for at least twenty-four (24) hours after my release from surgery or until further recovered from the effects of the anesthetics, medications and drugs that may have been given to me in the office or hospital. I agree not to drive after surgery and will have a responsible adult drive

_____ me or accompany me home after my discharge from surgery.

_____ I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires a general anesthetic.

If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgement or for procedures in addition to

_____ or different from those now contemplated, I request and authorize the doctor to do whatever he may deem advisable.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition, despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition would

_____ occur sooner without the recommended treatment.

_____ I have had an opportunity to discuss with Dr. Morris my past medical and health history, including any serious problems and/or injuries.

I agree to cooperate completely with the recommendations of Dr. Morris while I am under his care, realizing that any lack of same could

_____ result in a less than optimum result.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE TERMS, WORDS AND EXPLANATIONS REFERRED TO OR MADE IN THE ABOVE CONSENT TO THE OPERATION; THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN; AND THAT INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO CERTIFY THAT I READ AND WRITE ENGLISH.

Witness _____ Patient, Parent or Guardian _____ Date _____

Witness _____ Doctor _____ Date _____

* Patient is to initial each paragraph after reading.