CONSENT FOR ORAL SURGERY

PLEASE READ THROUGH EACH PARAGRAPH. PLEASE SIGN AND DATE ON BACK SIDE WHEN FINISHED. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR <u>BEFORE</u> SIGNING.

1. This is my consent for Slim Bouchoucha, D.D.S., M.S., any Oral and/or Maxillofacial Surgeon who is working with him to perform the following treatment/procedure/surgery:
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   ____

2. I understand that the purpose of the 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 are not limited to, the following: swelling, pain, infection, cyst formation, periodontal (gum disease), dental caries, malocclusion, pathologic fracture of jaw, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

3. Dr. Bouchoucha 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:

   A. Postoperative discomfort and swelling that may necessitate several days of at-home recuperation.
   B. Heavy bleeding that may be prolonged.
   C. Injury to adjacent teeth and fillings.
   D. Postoperative infection requiring additional treatment.
   E. Stretching of the corners of the mouth with resultant cracking and bruising.
   F. Restricted mouth opening for several days or weeks.
   G. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
   H. Fracture of the jaw.
   I. Injury to the nerve under teeth resulting in numbness or tingling of the chin, lip, cheek, gums and /or tongue on the operated side; this may persist for several weeks, months, or in rare instances, permanently.
   J. Opening into the sinus (a normal cavity situated above the upper teeth) requiring additional treatment.
   K. Referred pain to neck and ear.
   L. Other: ____

4. I understand that certain anesthetic risks, which could involve serious bodily injury can occur with local anesthesia. These include but are not limited to unfavorable reactions to the anesthetic drugs, nausea, vomiting, allergic reactions, even cardiac arrest. I consent to the administration of local anesthesia.

5. If any unforeseen condition should arise in the course of an operation, calling for the doctors judgement or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever deemed advisable.

6. 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 re-treatment, 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 recommended treatment.

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

8. I agree to cooperate completely with the recommendation of Dr. Bouchoucha while I am under his care, realizing that any lack of same could result in a less than optimum result.

9. I hereby authorize Dr. Bouchoucha or any other associates to photograph me while under his care and that all negatives, prints or slides may be used for such purposes and in a manner as may be deemed necessary, including scientific or medical publications.

Female patients:

1. If I am, or could be, or am found to be pregnant during the time of this treatment I understand and accept the risk that any medications given to me may cause birth defects or other problems with the unborn child.

2. It has been explained to me, and I understand, that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control, for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT AND THE EXPLANATION MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ANY INAPPLICABLE PARAGRAPHS WERE STRICKEN BEFORE I SIGNED. I ALSO STATE THAT I SPEAK, READ, AND WRITE ENGLISH.

____
Print Patient Name

____
Patient/Legal guardian's Signature Date

____
Witness' Signature Date

____
Doctor's Signature Date