

SONORA ORAL SURGERY

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Members

American Association of Oral and Maxillofacial Surgeons

INFORMED CONSENT FOR ORTHOGNATHIC SURGERY

Patient is to initial each paragraph after reading. If patient is a minor parent or guardian must initial.

_____ This is my consent for Dr. Slim Bouchoucha, D.D.S., M.S. and/or any other oral and maxillofacial surgeon working with him to perform a _____ as previously explained to me or other procedures deemed necessary or advisable to complete the planned operation. I also agree to use of a local and/or general anesthetic, sedation and analgesia depending upon the judgment of the oral and maxillofacial surgeon and anesthesiologist involved in my case.

_____ I have been informed and understand that occasionally there are complications of the surgery, drugs, and anesthesia including; pain, infection, swelling, bleeding that may be heavy or prolonged, discoloration, numbness and tingling of the lip, tongue, chin, gums, cheeks, and teeth which may be temporary or permanent; pain, numbness of phlebitis (inflammation of a vein) from intravenous and intermuscular injection; injury to and stiffening of the neck and facial muscles; the possibility that adjacent facial muscles may not function following the surgical procedure for an indefinite time; change in occlusion or temporomandibular (jaw) joint difficulty; injury to adjacent teeth or restorations in other teeth, or injury to soft tissues; and/or referred pain to the ear, neck, and head. Other potential complications could include nausea, vomiting, allergic reaction, bone fractures, bruises, delayed healing, sinus complications, openings from the sinus into the mouth, apparent facial changes, nasal changes, the possibility of secondary surgical procedures, loss of bone and the invested teeth, non-healing of the bony segments, devitalization (nerve damage which may require a root canal) of teeth and relapse.

_____ It has also been explained to me that this surgical procedure may of necessity involve the wiring of my teeth together. The inherent complications of that procedure have been explained to me and I agree to carry wire cutters with me at all time during the time my teeth are wired together in case of nausea or vomiting.

_____ I also agree not to use alcoholic beverages and unprescribed drugs and have been advised to avoid contact activities, people with known communicable diseases, and water sports for at least ten weeks.

_____ I agree and understand I am not to have and/or have not had anything to eat or drink for (8) eight hours before my surgery.

_____ 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, automobile, or hazardous devices, or work while taking such medications, and/or drugs; or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least 24 (twenty-four) hours after my release from surgery or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

_____ I agree to cooperate completely with the recommendations of Dr. Bouchoucha and/or any of his associates while I am under his care realizing that any lack of same could result in a less than optimum result.

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

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

The fee for services has been explained to me and is satisfactory and I understand there is no warranty or guarantee as to the result and/or cure and that my condition may return or become worse.

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

Patient's Signature Date

Parent or Legal Guardian (if under 18) Date

Spouse of interested co-signer Date

Witness (Professional staff member) Date

Surgeon Date