Catalano Oral Surgery & Implantology

JOSEPH M. CATALANO, D.D.S., P.C.

CONSENT FOR ORAL SURGERY/TOOTH EXTRACTION

You have the right to be informed about your condition and the recommended treatment plan so that you may make an informed decision as to whether or not to undergo the procedure after knowing the possible complications and risks involved. This disclosure is not meant to alarm you, but is rather an effort to properly inform you so that you may give or withhold your consent.

Patient Name: _____ **Date:** _____

Please read and initial all items. If you have any questions, please ask your doctor before initialing.

_____ 1. I hereby authorize Dr. Joseph Catalano and any assistants or associates to treat the condition(s) described as : _____

_____

_____ 2. The procedure(s) necessary to treat the condition(s) described above have been explained to me, and I understand the nature of the procedure(s) to be: _____

_____

_____

_____ 3. I have been informed of possible alternative methods of treatment (if any), including no treatment/leave as is.

_____ 4. I am aware that there are certain inherent and potential risks and side effects in any surgical procedure, and in this specific instance such risks include, but are not limited to, the following:

_____ a. Postoperative discomfort and swelling that may require several days of at-home recuperation

_____ b. Prolonged or heavy bleeding that may require additional treatment

_____ c. Injury or damage to adjacent teeth or roots of adjacent teeth

_____ d. Postoperative infection or delayed healing (dry socket) that may require additional treatment

_____ e. Stretching of the corners of the mouth that may cause cracking and may heal slowly

_____ f. Restricted mouth opening during healing sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints, especially when temporomandibular joint (TMJ) problems already exist

_____ g. The decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications

_____ h. Fracture of the jaw or of thin bony plates

_____ i. Injury to the nerve underlying lower teeth resulting in numbness or tingling of the chin, lip, teeth, cheek, gums, roof of mouth, and/or tongue which may persist for several days, weeks, months, or (in rare instances) permanently

_____ j. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery or treatment

_____ k. Bruising of the cheeks and/or facial area which may heal slowly

_____ l. Allergic reactions (previously unknown) to any medications used in the procedure or postoperatively

_____ m. Local anesthesia injuries to nerves, causing temporary or permanent numbness or tingling of jaw, cheek, gums, teeth, roof of mouth, lip, chin, and/or tongue

_____ n. Local anesthesia injuries in the lower jaw/tongue that may lead to loss of or decreased taste

_____ o. Other: _____

_____ 5. I have disclosed to my treating oral surgeon any history of past or current treatment with oral or intravenous bisphosphonates in my treatment for: osteoporosis/osteopenia/arthritis/cancer bone metastases. Failure of disclosure can lead to complications in healing, including but not limited to osteonecrosis of the jaw bone. Oral forms include: Alendronate (Fosamax), Etidronate (Didronel), Residronate (Actonel), Tiludronate (Skelid), and Ibandronate (Boniva). Intravenous forms include: Pamidronate (Aredia) and Zoledronate (Zometa).

_____ 6. It is possible that during the course of the procedure(s) unforeseen conditions may be revealed which will necessitate additional treatment from those set forth in item 2 above. I authorize my doctor and his staff to perform such treatment only as necessary for the desired result in the exercise of professional judgment.

_____ 7. In connection with the procedure(s) set forth in item 2 above, I consent to the administration of:

☒ Local Anesthesia ☐ General Anesthesia
☐ IV Sedation ☐ Nitrous Oxide
☐ Oral Sedation

_____ 8. I am aware that certain medications, drugs, anesthetics, and prescriptions which I may be given can cause drowsiness, lack of coordination, and/or lack of awareness which may be increased by the use of alcohol or other drugs. I have been advised not to operate any vehicle or hazardous machinery and not to work while taking such medications or until fully recovered from the effects of same. I understand this recovery may take up to twenty-four (24) hours or more after I have taken the last dose of the medication. If I am to be given sedation medication before or during my surgery, I agree not to drive myself home and will have a responsible adult drive me home and accompany me until I am fully recovered from the effects of sedation medication. I will not operate any vehicle or hazardous machinery for twenty-four (24) hours following my sedation.

_____ 9. Due to the potential for nausea and vomiting under IV anesthesia, I understand that I must not eat or drink **anything** by mouth for the duration of time from eight (8) hours prior to my scheduled surgery time until I am discharged from surgery. **To do otherwise may be life threatening!**

_____ 10. I fully understand that the intended result is not and cannot be guaranteed or warranted.

_____ 11. I give you permission to consult any of my physicians regarding medical history and/or conditions that may affect my treatment.

_____ 12. I certify that I speak, read, and write English or have been afforded the use of a translator.

_____ 13. I certify that I have read and fully understand this Consent for Oral Surgery and that all blanks were filled in prior to my initials and signature.

Please consult your doctor if you have any questions or concerns regarding this consent.

_____ _____

Signature of Patient or Parent/Legal Guardian of Patient Date

_____ _____

Signature of Witness Date

_____ _____

Signature of Treating Oral Surgeon Date