Southern FAMILY DENTISTRY

Dr. Nathan Nash, DDS

1363 Union University Dr, Jackson, TN 731-300-4545
2025 South 1st Street, Milan, TN 731-686-1151

Informed Consent for Oral Surgery, Implants and Dental Extractions

Complications: Complications from dental procedures are very rare, but it is important to understand the possibilities both with and without treatment. Inherent Risks: Oral surgery (including implants &dental extractions) has certain inherent risks

This form and your discussion with you doctor are intended to help you make informed decisions about your surgery. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

5. **Injury to the nerves:** This would include injuries causing numbness of the lips, tongue, and any tissue of the mouth, and/or cheeks or face. This numbness which could occur may be of temporary nature, lasting a few days, a few weeks, a few months, or could possibly be permanent and could be the result of the surgical procedures or anesthetic administration.
6. **Bleeding, bruising, swelling:** Bleeding may last several hours. If profuse, you must contact us as soon as possible, Some swelling is normal, but if severe, you should notify us, bruises or hematomas may persist for some time.
7. **Dry Socket:** This occurs on occasion when teeth are extracted and is a result of a blood clot not forming properly during the healing process. Dry sockets can be extremely painful if not treated.
8. **Sinus involvement:** In some cases, the root tips of upper teeth lie in close proximity to the sinuses. Occasionally during extraction or surgical procedures, the sinus membrane may be perforated. Should this occur, it may be necessary to have the sinus surgically closed. Root tips may need to be retrieved from the sinus.
9. **Infection:** No matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile or infected oral environment, for infections to occur postoperatively. At times, these may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, attention should be received as soon as possible.
10. **It is my responsibility to seek attention should any undue circumstances occur post-operatively and I shall diligently follow any pre-operative and post-operative instructions given to me.**

1. **Fractured jaw, roots, bone fragments, or instruments:** Although extreme care will be used, the jaw, teeth roots, bone spicules, or instruments used in the extraction procedure may fracture or be fractured, requiring retrieval and possibly referral to a specialist. A decision may be made to leave a small piece of root, bone fragment, or instrument in the jaw when removal may require additional extensive surgery that could cause more harm and add to the risk of complications.
2. **Injury to adjacent teeth or fillings:** This could occur at times no matter how carefully surgical procedures and/or extractions are performed.
3. **Bacterial endocarditis:** Because of the normal existence of bacteria in the oral cavity, the tissues of the heart, as a result of reasons known or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and bacterial endocarditis (in infection in the heart) could occur. It is your responsibility to inform the dentist of any heart problems known or suspected.
4. **Unusual reactions to medications given or prescribed:** Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics can render these contraceptives ineffective. Other methods of contraception must be utilized during the treatment period.

_____I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate & complete medical history including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

_____I understand the use of tobacco and alcohol is detrimental to the success of my treatment.

_____I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications, risks, or less than optimal results.

_____I understand and accept that the doctor cannot guarantee the results of the procedure or the length of time needed to complete my treatment. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

Informed consent: I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment, implant and/or extraction of teeth and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Nathan Nash. DDS and his staff to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient or Guardian's Signature **Date**