ALIN N. CHERA, D.D.S.
INFORMED CONSENT
ORAL AND MAXILLOFACIAL SURGERY
AND ANESTHESIA

Dear Patient,

You have a right to be informed about your diagnosis and planned surgery so that you may make a decision whether to undergo a procedure after knowing the risks and hazards. This disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so you may give your informed consent to the procedure. Please be assured that we will do our best at all times to make healing as rapid and as trouble-free as possible.

POSSIBLE COMPLICATIONS (May be variable in occurrence):

_____ **ALL SURGERIES**

1. Soreness, pain, swelling, bruising and restricted mouth opening during healing, sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.
2. Bleeding, usually controllable, but may be prolonged and require additional care.
3. Drug reactions or allergies.
4. Infection, possibly requiring additional care, including hospitalization and additional surgery.
5. Stretching or cracking at the corners of the mouth.

_____ **ALL TOOTH EXTRACTIONS**

1. Dry socket (delayed healing), causing discomfort a few days after extraction requiring further care.
2. Damage to adjacent teeth or fillings
3. Sharp ridges or bone splinters, may require additional surgery to smooth area.
4. Portions of tooth remaining – sometimes fine root tips break off and may be deliberately left in place to avoid doing damage to nearby vital structures such as nerves or the sinus cavity.

_____ **LOWER TEETH**

1. NUMBNESS: Due to the proximity of tooth roots, (especially wisdom teeth), and other surgical sites to nerves, it is possible to lose function of nerves following the removal of the tooth or surgery in the area. The lip, chin, teeth, gums or tongue could thus feel numb (resembling local anesthesia injection). There may also be pain, loss of taste and change in speech. This could remain for days, weeks or rarely, permanently.
2. JAW FRACTURE: While quite rare, it is possible in difficult or deeply impacted teeth and usually requires additional treatment, including surgery and hospitalization.

_____ **UPPER TEETH**

1. SINUS INVOLVEMENT: Due to the closeness of the roots of upper back teeth to the sinus or from the root tip being displaced into the sinus, a possible sinus infection, and/or sinus opening may result which may require medication and/or later surgery to correct.

_____ **ANESTHESIA**

1. LOCAL ANESTHESIA: Certain possible risks exist that, although rare, could include pain, swelling, bruising, infection, nerve damage, and unexpected reactions which could result in heart attack, stroke, brain damage and/or death.
2. INTRAVENOUS OR GENERAL ANESTHESIA: Certain possible risks exist that, although uncommon, may include nausea, pain, swelling, inflammation and/or bruising at the injection site. Rare complications include nerve or blood vessel injury (phlebitis) in the arm or hand, and allergic or unexpected drug reactions, pneumonia, heart attack, stroke, brain damage and/or death.

If I am having intravenous or general anesthesia, I understand that I have NOT HAD ANY FOOD OR DRINK FOR SIX HOURS before my appointment. To do otherwise MAY BE LIFE-THREATENING! I agree not to drive for the next 24 hours, and will have a responsible adult accompany me.

ALTERNATIVE TREATMENT OPTIONS:_____

PATIENT NAME: _____

I hereby authorize Dr. Alin N. Chera, D.D.S., and staff to perform the following procedure(s):
_____
_____
_____

and to administer an anesthesia. I understand the doctor may discover other or different conditions that may require additional or different procedures than those planned. I authorize him/her to perform such other procedures, as he/she deems necessary in his/her professional judgment in order to complete my surgery. I have discussed my past medical history with my doctor, and have disclosed all diseases and medication and drug use. I agree not to operate vehicles or hazardous machinery while taking prescription narcotic pain medications. I have received written postoperative instructions regarding home care, including emergency after-hours phone numbers. I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following treatment, I agree to report them to the doctor, and his/her designated agent as soon as possible. I have read and discussed the preceding with the doctor, and believe that I have been given sufficient information to give my consent to the planned surgery. No warranty or guarantee has been made as to the results or cure.

I certify that I speak, read and write English, and have read and fully understand this Consent for Surgery, or if I do not, I have had someone translate so that I can understand the consent form. All blanks were filled in prior to my initials and signature.

_____ _____
Patient Signature (or Legal Guardian) Date

_____ _____
Witness Signature Date

_____ _____
Doctor Signature Date