Informed Consent for Oral Surgery

The following applies for periodontal flap surgery, flap and curretage, incision an drainage, apicoectomy, biopsy, excision of soft/hard tissue lesions, grafts, impacted canine exposure, repair of oral or facial lacerations and other surgeries as specified.

Post-operative risks of the proposed surgery include, but are not limited to pain, restricted mouth opening for several days, weeks, or longer, paresthesia (numbness) of the jaw or gum nerves which persist for several weeks, months, or in remote instances, permanently, gum recession (shrinkage), temporary or in rare instances permanent interference with phonetics (speech sounds), clicking or pain of the temporomandibular joints (jaw joints), tooth sensitivity to hot or cold for days, weeks, or on occasion, several months, transient or in some instances permanent tooth mobility (looseness) in selected areas, food lodging between the teeth after meals, requiring cleaning devices such as floss for removal and unesthetic exposure of crown margins of teeth in the surgery area. Further, I have been informed of the other possible alternative and/or supplemental methods of treatment, if any.

I further understand that if no treatment is rendered my present condition will probably worsen in time. No guarantee, warranty, or assurance has been given me that the proposed treatment will be successful to my complete satisfaction. Due to individual differences there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the best of care. However, it is the doctor's opinion that therapy will be helpful, and that any further loss of supporting tissues or bone would occur sooner without the recommended treatment. I understand that long term success requires my long-term performance of mechanical plaque removal (daily home care) and my availability for periodic periodontal maintenance visits (professional recare).

If any unforeseen condition should arise in the course of the procedure, or the need for procedures different from those now contemplated, I further request and authorize the doctor to do whatever he may deem advisable.
I consent to photographs of my oral and facial structures and their publication for educational and scientific purposes and to the use of sterilized cadaver bone if I am receiving a bone graft. I give my consent for

_____Dr Ed Gracza _____Dr Jane Gracza _____ Dr Jon Hallie

to perform the following surgery, _____

name or description of surgical procedure

on me or my dependent. I certify that I have had an opportunity to read and fully understand the terms and words in this document and the explanations made or referred to, and that according to the mutual agreement of the undersigned, additions, if any, were made and initialed and applicable paragraphs, if any, were stricken before I signed.

_____ _____

Patient Signature Date Dentist Signature Date

_____

Witness Signature Date

Karlstad Dental Clinic PO Box 223 223 S Main St Karlstad, MN karlstaddental.com 218-436-2944 kdc @wiktel.com
Roseau Dental Clinic PO Box 280 903 3rd St NE Ste. A Roseau, MN 567651 roseaudental.com 218-450.2944 rdc@wiktel.com