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CORONECTOMY CONSENT FORM

Patient Name: _____ **Date:** _____

You have the right to be informed about your diagnosis and planned surgery so you may make a decision whether to undergo a procedure after knowing the risks. This disclosure is not meant to frighten or alarm you. The chances of these complications occurring are small. It is simply an effort to make you better informed about your surgery.

1. **I have been informed of and understand the potential risks related to this surgical procedure include but are not limited to:**

   a) Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, retention of tooth structure, bone or foreign material in the body, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials;

   b) Nerve injury, which may occur from the surgical procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent and/or require additional treatment

   c) Development of a cyst or other growth around the tooth root.

   d) The root may move over a period of years requiring removal.

   e) The root fragment may become loose during the surgery, and the entire tooth may need to be removed.

   f) Sharp ridges or bone splinters may form where the tooth was removed, possibly requiring additional surgery.

2. **I have elected to proceed with the anesthesia(s) indicated below.**

   LOCAL NITROUS OXIDE IV SEDATION GENERAL ANESTHESIA

   I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:

   a) LOCAL ANESTHESIA: Certain possible risks exist that, although rare, could include pain, swelling, bruising, infection, nerve damage, and unexpected allergic reactions.

   b) INTRAVENOUS SEDATION OR GENERAL ANESTHESIA: Certain possible risks exist that, although uncommon, could include nausea, pain, swelling, inflammation, and/or bruising at the injection site (phlebitis).

   c) Rare complications, include allergic or unexpected drug reactions, or other life-threatening conditions.

d) **IF I AM TO HAVE INTRAVENOUS SEDATION OR GENERAL ANESTHESIA, I UNDERSTAND THAT I AM TO HAVE NO FOOD OR DRINK FOR EIGHT (8) HOURS BEFORE MY APPOINTMENT. TO DO OTHERWISE MAY BE LIFE THREATENING.**

e) I have been made aware that certain medications, drugs, anesthetics, and prescriptions which I may be given can cause drowsiness, lack of coordination and awareness. The use of alcohol can increase the effects of these drugs. I have been advised not to operate any vehicle or hazardous machinery and not to return to work while taking such medications, or until fully recovered from the effects of the same. I understand that this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am to be given sedative medication during my surgery, I agree not to drive myself home and will have a responsible adult accompany me until I am fully recovered from the effects of the sedation. **I ALSO UNDERSTAND THAT IF I AM GIVEN AN IV SEDATION, THERE IS NOT GUARANTEE THAT I WILL BE COMPLETELY ASLEEP DURING MY PROCEDURE. I UNDERSATND THAT IN SOME INSTANCES, PATIENTS UNDERGOING SURGERY UNDER IV SEDATION CAN REMEMBER PORTIONS OR POSSIBLY ALL OF THE PROCEDURE, INCLUDING SOME PAIN.**

3. ALTERNATIVE TREATMENT OPTIONS:

I hereby authorize Drs. Monesmith & Wood and their staff to perform the following procedures:

It has been explained to me that during the course of surgery, unforeseen conditions may be revealed which necessitates extension of the original procedure or a different procedure from that which was planned. In rare cases, it may not be possible to continue with the procedure. I authorize my doctor and his staff to perform such procedure(s) that are necessary and desirable in the exercise of professional judgment.

I have had an opportunity to discuss my past medical history with my doctors, including psychological disorders, drug use, medications I am taking, or other problems which may affect t my anesthesia or surgery. I have truthfully revealed all aspects of my health history. It has been explained to me that if I am taking birth control pills that additional, alternative methods of birth control will be necessary while taking any drugs prescribed by this office for my entire cycle.

I understand that although good results are expected, the nature of all possible complications and individual patient differences cannot be accurately anticipated and therefore a perfect result is not and cannot be guaranteed or warranted.

I certify that I speak, read, and write English and have read and fully understand both pages of this consent for surgery and that all blanks were filled in prior to my signing this form. I have discussed the preceding with my doctor and all my questions have been answered to my satisfaction and I have made a voluntary choice to proceed with the proposed surgery.