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CONSENT FOR TREATMENT TO REPAIR FACIAL/DENTAL INJURY

Patient Name: _____ **Date:** _____

1) **The proposed treatment has been outlined for me in layman's terms and possible complications and side effects have been discussed, including but not limited to:**

a) Damage to, or loss of, teeth in the area of the trauma or fracture; loss of vitality of those teeth with requirement for future root canal therapy; loss of dental restorations; devitalization of bone and soft tissue in the area of trauma which may result in some loss of tissue.

b) Post-operative increased swelling, discomfort, bruising, bleeding, hematoma (blood clot), wound infection, sinusitis and limitation of function, any of which may require further care.

c) Reaction to foreign material which may have been introduced into the wound by the trauma, or "tattooing" of the skin or mucosa from particles of foreign material.

d) Change in occlusion (bite) and jaw function after treatment; secondary problems of the jaw joint (TMJ) which may be prolonged, or even permanent, and which may require future treatment. I also understand that additional treatment may be necessary postoperatively, including (but not restricted to) physical therapy, reconstructive dentistry, and orthodontics.

e) Scarring either inside or outside of the mouth, depending on the nature and force of the trauma and the locations of certain incisions required in treatment.

f) Facial muscle weakness, particularly of the lip, eyelid or other muscles of expression caused by injury to motor nerves in the area of the trauma. Such weakness may be partial or total and may be temporary or permanent.

g) Sensory nerve injury causing pain, numbness, or other sensory alterations anywhere in the mouth, tongue, cheek, lip and areas of facial skin which may be temporary or permanent.

h) Wiring the teeth together during the time required for healing of bone fractures will significantly reduce oral hygiene effectiveness, which may then lead to, or worsen, periodontal (gum disease), bleeding gums, discomfort and loosening of teeth. Following treatment for facial injury, any such conditions must be treated. Jaw wiring will decrease normal diet and cause temporary weight loss.

i) Certain wires, screws, plates, splints or other fixation devices may be introduced, and some may require later removal

j) Non-union or malunion of bony fractures, possibly requiring re-treatment including bone grafting. Some cosmetic or functional deformity may occur in areas adjacent to the trauma or repair.

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. I agree to cooperate with my doctor's recommendations, lack of cooperation could result in suboptimal result.