

CONSENT FOR TREATMENT TO REPAIR FACIAL/DENTAL INJURY

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Patient's Name

Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

____ 1. I authorize Dr. and his/her authorized staff to treat my condition(s) diagnosed as: _____

____ 2. The procedure(s) necessary to treat the condition(s) noted above has/have been explained to me, and I understand it/them to be: _____

____ 3. Other options/alternatives to this procedure(s) include no treatment at all or: _____

I understand these options, including benefits and risks of each.

____ 4. The proposed treatment has been outlined for me in laymen'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 swelling, discomfort, bruising, bleeding, hematoma (blood clot), wound infection, sinusitis and limitation of function, any of which may require further care.

____ C. Adverse or allergic reactions to medications or anesthesia causing multiple side effects, some of which may be serious and require additional care or hospitalization.

____ D. 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.

____ E. 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.

____ F. 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.

____ G. 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.

____ H. 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.

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- _____ I. 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.
 - _____ J. Certain wires, screws, plates, splints or other fixation devices may be introduced, and some may require later removal.
 - _____ K. Non-union or malunion of bony fractures, possibly requiring re-treatment. Some cosmetic or functional deformity may occur in areas adjacent to the trauma or repair.
- _____ 5. I understand that additional injury may be discovered during treatment that might necessitate a change in approach or a different procedure from those explained above and I authorize my doctor to perform such procedures that are necessary and advisable in the exercise of professional judgment.
- _____ 6. I understand that this is complex treatment and there can be no guarantee of complete resolution of my present symptoms or jaw/teeth/facial bone injury. Occasionally there may be increased symptoms post-operatively (for example, numbness). I also understand that additional treatment may be necessary post-operatively, including (but not restricted to) physical therapy, reconstructive dentistry, orthodontics, re-treatment of bone fractures including bone grafting, removal of certain fixation devices, or TMJ treatment. I agree to cooperate with my doctor's recommendations during treatment, realizing that lack of cooperation will result in a less-than-optimal result.
- _____ 7. I have discussed my past medical history with my doctor and have disclosed all diseases and medications, including alcohol and drug use (past and present).
- _____ 8. I have been told of my option for a second opinion regarding the proposed treatment from another qualified professional.
- _____ 9. **ANESTHESIA**
The anesthetic I have chosen for my surgery is:
- Local Anesthesia
 - Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
 - Local Anesthesia with Oral Premedication
 - Local Anesthesia with Intravenous Sedation
 - General Anesthesia
- _____ 10. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although rare, may be unfortunate side effects of IV anesthesia, and offer increased risk when jaws are wired together. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

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____ 11. YOUR OBLIGATIONS IF IV ANESTHESIA IS USED

- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
- B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
- C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!
- D. **However**, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water.**

INFORMATION FOR FEMALE PATIENTS

- ____ 1. I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

CONSENT

I have had an opportunity to have all my questions answered by my doctor, that all blanks on this form were filled in prior to my signing, and I certify that I speak, read and write English. My signature below signifies that I understand the surgery and anesthetic that is proposed for me, together with the known risks and complications associated. I hereby give my consent for such surgery and the anesthesia I have chosen.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness' Signature

Date