RTC Dental
703-956-9444

Informed Consent
For Oral and Maxillofacial Surgery

Patient Name_____

Procedures: Surgical removal of tooth/teeth number(s): _____

Alternatives to Surgery: Risks to my health if the above procedure is not performed include but are not limited to:

Infection;
Cyst or tumor formation;
Periodontal (gum) disease; and
Increased risk for complications if removal is required at a later time.

Possible Complications which have been discussed with me include but are not limited to:

1. Injury to the nerves, to the lower lip, and tongue causing numbness which could be permanent;
2. Bleeding and/or bruising which may be prolonged;
3. Dry socket;
4. Involvement of the sinus above the upper teeth;
5. Infection;
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and increased risk of complications;
7. Injury to adjacent teeth or fillings; and
8. Unusual reaction to medications given or prescribed
9. Mandibular Nerve Injury (lower jaw).
10. Additionally, I understand that a perfect result cannot be guaranteed. If any unforeseen conditions arise during the procedure, I request and authorize the doctor to do whatever he deems advisable to correct the condition.

I agree to cooperate completely with Dr._____, and will follow post-operating instructions to the best of my ability for my own comfort and safety. I have had the opportunity to ask questions concerning these procedures.

_____ _____
Patient, Parent or Guardian Date

_____ _____
Doctor Witness