Park Family Dental
24047 W. LOCKPORT STREET,SUITE 207
Plainfield, IL 60544
(815) 267-7878

CONSENT FOR ORAL SURGERY AND ANESTHESIA

Patients Name _____ Date of Birth_____

This is my consent for Dr. Roh to perform the following treatment/procedure/ surgery:_____
_____
_____ as previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

I understand that the purpose of the procedure/surgery is to treat and to possibly correct my diseased oral/maxillofacial tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time, and the risks to my health may include, but are not limited to, the following: swelling; pain; infection; cyst formation; periodontal (gum) disease; dental caries; malocclusion; pathologic fracture of jaw; premature loss of teeth; and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

Dr. Roh has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to: (check items applicable)

_____ 1. Postoperative discomfort and swelling that may necessitate several days of home recuperation.
_____ 2. Heavy bleeding that may be prolonged.
_____ 3. Injury to adjacent teeth and filings.
_____ 4. Postoperative infection requiring additional treatment.
_____ 5. Stretching of the corners of the mouth with resultant cracking and bruising.
_____ 6. Restricted mouth opening for several days or weeks.
_____ 7. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
_____ 8. Breakage of jaw.
_____ 9. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side: this may persist for several weeks, months, or, in remote instances, permanently.
_____ 10. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
_____ 11. Osteonecrosis of the jaw may accur.
_____ 12. Other_____

*** I agree and understand I am not to have and/or have not had anything to eat or drink for over 8 hours before my surgery. _____**

I consent to administration of such local and/or general anesthesia as deemed necessary by Dr. Roh to accomplish the proposed procedure.

I certify that I have not taken any street drugs or non prescribed medication within the last 24 hrs., including but not limited to cocaine, heroin, and marijuana. I realize that by not revealing this

information, I place myself under significant risk for the surgical procedure and the anesthesia.

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus I have been advised not to operate any vehicle, automobile, or hazardous devices, or work while taking such medications and/or drugs; or until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least 24 hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires a general anesthetic.

If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgement or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he/she may deem advisable.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I have had an opportunity to discuss with Dr. Roh my past medical and health history including any serious problems and/or injuries.

I agree to cooperate completely with the recommendations of Dr. Roh while I am under his/her care, realizing that any lack of same could result in a less than optimum result.

I understand that any tissue specimen taken for a biopsy will be submitted to a pathologist for examination and diagnosis. I also understand that I will be billed separately for this.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT FORM AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE THAT I READ AND WRITE ENGLISH.

_____	_____
Witness	Patient, Parent, or Guardian
_____	_____
Witness	Doctor
_____	
Date	