Kamloops Oral Surgery and Implant Center

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CONSENT FOR ORAL SURGERY AND SEDATION

You have the right to be informed about the planned surgery and possible risks involved. This disclosure is not meant to alarm or frighten you. It is simply an effort on our part to provide information so that you can make an informed decision whether to give or withhold your consent to surgery.

I, _____ hereby authorize Dr. B. Rishiraj and staff to perform the following:

_____

for _____ (patient) and to administer anesthetic which I have chosen, which is:

☐ Local Anaesthetic ☐ Intravenous Sedation ☐ General Anaesthetic

_____ 1. 1 understand that there are known complications of surgery and anesthesia which include, but are not limited to, the following: pain and discomfort; swelling; bleeding; bruising; infection. Changes in the bite or restricted mouth opening due to stress on the jaw joint may occur. There is also the possibility of injury to adjacent tissues of the face, bone, fractures, delayed healing, dry sockets and referred pain to the ear or head.

_____ 2. With tooth extractions I understand that there may be unavoidable damage to adjacent teeth and/or fillings, sharp ridges or bone splinters that may require later surgery to smooth and remove, where small fragments of tooth structures which may be left in place to avoid damage to vital structures such as nerves or the sinus.

_____ 3. Lower tooth roots may be very close to the nerve and surgery may result in pain and/or a numb/tingling/slight burning feeling of the chin, lips, cheeks, gums, teeth or tongue lasting for several weeks, months, or rarely, indefinitely. On upper teeth with roots that are close to the sinus, a sinus infection may develop, a root tip may enter the sinus, and/or an opening for the mouth to the sinus may be created, which could require medication and/or surgery to address.

_____ 4. Anesthetic risks include: discomfort, bruising, infection, drug or allergic reaction. When medications are placed in a vein, there may be inflammation at the injection site (phlebitis) which may cause prolonged discomfort or disability and may require further care. Nausea and vomiting, although uncommon, maybe unfortunate side effect of intravenous anesthesia. Very rare risks include the developments of heart irregularities, stroke and/or cardiac arrest.

_____5. 1 have had all of my questions concerning this procedure answered to my satisfaction. If unforeseen circumstances require additional procedures to those described above, I give permission for professional judgment to be exercised

_____ 6. I have informed Dr. Rishiraj of my complete medical information to date.

_____7. **In the event that this treatment, or any part of this treatment is not covered by my dental plan due to financial limits contract exclusions or deductibles, I assume responsibility to pay any outstanding balance in full.**

My signature signifies that I fully understand the above risks involved in the proposed surgery and anesthesia administration, that we have discussed alternative methods of treatment, if any, and that I consent for Dr. B. Rishiraj with the surgery and anesthesia as indicated above. I agree to cooperate with the recommendations of Dr. B. Rishiraj while I am under his care, realizing that any lack of same could result in a less than optimum result. I agree to attend post-operative assessment appointment as scheduled. In addition, my initials above signify that I have read, understood and accepted the risks stated in the paragraphs to the right of them.

_____ _____
Patient's (or Legal Guardian's) Signature Date

_____ _____
Witness's Signature Date

_____ _____
Doctor's Signature Date