



CONSENT FOR ORAL SURGERY WITH LOCAL ANESTHETIC

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). I am choosing: Local Anesthetic

____ 1. I 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, fracture, 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 structure which may be left in place to avoid damage to vital structure 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 numbness/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 from the mouth to the sinus may be created, which could require medication and/or surgery to address.

____ 4. I 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 judgement to be exercised.

____ 5. I have informed Dr. Rishiraj of my complete medical information to date.

____ 6. In the event that this treatment, or any part of this treatment is not covered by my dental plan insurance 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 Dr. S. Zahedi with the IV 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 appointments, 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

Dr. B. Rishiraj

Date