



DEPARTMENT OF THE NAVY

NAVAL DENTAL CENTER  
2310 CRAVEN ST.  
BOX 368147  
SAN DIEGO, CALIFORNIA 92136-5596

NAVDENCENSIEGOINST 6320.3 CH-1  
OOQ  
23 OCT 1997

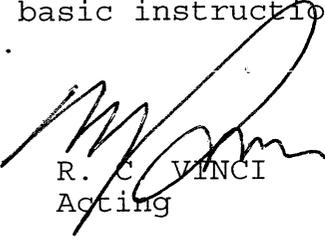
NAVDENCEN SAN DIEGO INSTRUCTION 6320.3 CHANGE TRANSMITTAL 1

From: Commanding Officer

Subj: INFORMED CONSENT FOR DENTAL TREATMENT

Encl: (1) Replacement page (2)

1. Purpose. To update basic instruction.
2. Action. Replace page 2 of basic instruction with enclosure (1) of this change transmittal.

  
R. C. VINCI  
Acting

Distribution:  
List 1, Case 2





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BOX 368147  
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NAVDECENS DIEGOINST 6320.3  
OOQ  
18 JUN 1996

NAVDECENS DIEGOINST 6320.3

Subj: INFORMED CONSENT FOR DENTAL TREATMENT

Ref: (a) NAVMEDCOMINST 6320.16  
(b) BUMED ltr 6320 Ser 631/0049 of 19 Jan 90

Encl: (1) NDCSD 6320/9 Informed Consent for Dental Implants  
(2) NDCSD 6320/5 Informed Consent for Endodontic Surgery  
(3) NDCSD 6320/1 Informed Consent for Pediatric Dentistry  
(4) NDCSD 6320/4 Informed Consent for Periodontic Surgery  
(5) NDCSD 6320/3 Informed Consent for Oral Surgery  
(6) Authorization to Consent to Dental Care

1. Purpose To set forth the requirements for obtaining consent for dental treatment at Naval Dental Center, San Diego per references (a) and (b).

2. Cancellation NAVDECENS DIEGOINST 6300.1A

3. Background With few exceptions, every patient has the right to be examined and treated only when and in the manner that they authorize. This individual right is mandated in the total practice of dentistry and is not limited to surgical procedures alone. Documentation must be maintained which demonstrates that patients are properly informed concerning the scope and possible undesirable outcomes of proposed dental treatment. Healthcare providers must provide the patient adequate counseling necessary to obtain consent for treatment and appropriately document that the process has occurred.

4. Policy Informed consent will be obtained from all beneficiaries treated at the Naval Dental Center, San Diego utilizing the guidance contained in this instruction. The appropriateness of consent practices within the command will be monitored as a regular part of dental records review.

5. Procedures

a. Types of consent EXPRESS consent (oral or written) is obtained through open discussion between the provider and the patient. Written consent will be obtained for dental implants, endodontic surgery, oral surgery, orthodontic treatment, pediatric dentistry, periodontal surgery, and administration of nitrous oxide/inhalation sedation. IMPLIED consent arises by reasonable inference from the conduct of the patient even though



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specific words of consent may not be communicated. This may be utilized for routine restorative dentistry and local anesthesia.

b. Information to be provided The provider must describe the proposed procedure in lay terms so that the patient understands the nature of what is proposed. The risks of the proposed course must be explained, along with alternative and nontreatment options. The provider need not make disclosure of risks when the patient specifically requests not to be informed.

c. Who provides information The duty to inform and explain rests with the healthcare provider.

d. Documentation Regardless of the method used to inform the patient, the clinician must note the disclosure in the dental record.

(1) Signed consent forms will be filed on the right side of the dental record.

(2) Consent for routine restorative non-invasive restorative dentistry (not including soft tissue or bone) will be documented by the doctor's signature on the EZ603 immediately following the Plan entry of the S.O.A.P. at the time of examination and treatment planning.

(3) Any CHANGES to the treatment plan must be documented in writing on the 603 and recorded as PTINF - not merely added to the original S.O.A.P.

(4) Written consent will be documented using:

NDCSD 6320/x for Dental Implants  
NDCSD 6320/x for Endodontic Surgery  
NDCSD 6320/x for Pediatric Dentistry  
NDCSD 6320/x for Periodontal Surgery  
NDCSD 6320/x for Oral Surgery  
NAVMED 6620/7 for Orthodontic Treatment  
SF-522 for Nitrous oxide/Intravenous Sedation

(5) A witness over the age of 18 must sign all consent forms. The witness shall be present at the time consent is given. It is not advisable for a family member or a staff member participating in the procedure to be a witness.

e. Who may consent The determination of who has authority to consent to dental treatment is based on an evaluation of the competency of the patient. If competent, the patient alone has the capacity to consent. Competency refers to the ability to understand the nature and consequences of one's decisions. In the absence of contrary evidence, it may be assumed that the patient presenting for treatment is competent. If the patient is incompetent either by reason of statutory incompetency (e.g. a minor under 18 years old) or by reason of physical or mental impairment, then the inquiry must turn to who has the legal capacity to consent to treatment on behalf of the patient. In

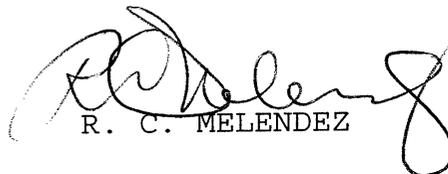
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some instances, parents may give authorization for consent to treatment to an adult third party. If a third party presents the minor for treatment with proper authorization, similar to the example in enclosure (6), the third party can give valid consent. In the absence of such authorization every effort should be made to contact the parents. If they cannot be contacted, the attending dental officer must determine the necessity of treating the minor at the immediate time. If the care is elective, or not of immediate nature, the dental officer should defer treatment until consent can be secured.

f. Emergency situations Consent prior to treatment is not necessary where treatment appears to be immediately required and necessary. The existence and scope of the emergency should be adequately recorded by the dentist. The nature of most dental emergencies is not life threatening and would allow for obtaining informed consent prior to emergency treatment.

g. Duration of consent Informed consent is good as long as the conditions that gave rise to the consent are valid. If there has been a change in the treatment plan OR a prolonged time has elapsed since the original consent was obtained, the provider will validate the consent.

h. Forms SF-522 is available through the standard stock system: NSN 7540-00-634-4165. NAVMED 6670/2 is available from BUMED (MED-06). NDCSD forms (enclosures 1-5) may be obtained from the command Performance Improvement Coordinator and duplicated locally.



R. C. MELENDEZ

Distribution:  
List 1, Case 2

18 JUN 1996

## INFORMED CONSENT FOR DENTAL IMPLANTS

This is my consent for the surgical placement, uncovering and restoration of dental implants. I understand the procedure will involve the placement of titanium metal dental implant(s) into my jaw. The implants must heal for 4 to 8 months before being surgically uncovered so the restoration can be made at a later date. The implants may then be used to support and retain partial dentures, complete dentures, or to replace single missing teeth. I have been informed of alternative methods of treatment along with their risks and benefits.

I understand that there is no way to predict the gum and bone healing response of each patient following implant placement. Factors such as general health, smoking, alcohol and poor diet may affect healing and the success of the implant.

It has been explained that there are risks associated with this treatment, including the possibility of pain, bleeding, swelling, and infection. Numbness and/or tingling of the lip, tongue, chin, gums, cheeks and any existing teeth can also occur, which may be temporary or permanent. Additionally, sinus complications, openings from the jaw to the mouth, bone fractures, injuries to adjacent tissues and apparent facial changes are possible. These problems may require later surgical correction including removal of the device. Furthermore, it has also been explained to me that the implant(s) may not work, or may later fail. I understand that failure of this implant method may result in failure of the bridge, partial or full denture but will usually not interfere with other types of future conventional denture treatment should that be necessary.

(Please read and initial the following statements)

\_\_\_\_\_ I agree to the use of a local anesthetic, and/or sedation depending upon the judgement of the surgeon(s) involved in my care.

\_\_\_\_\_ I understand that a bone graft material may need to be added to help support the implant. The graft material is usually a decalcified freeze-dried bone which is obtained by certified tissue banks under sterile conditions from human donors with no known diseases. The bone is then processed under strict conditions which are known to kill bacteria and viruses. While transmission of infection by implanted biologic material can never be ruled out 100% of the time, this material is considered to be extremely safe with no instance of transmitted infection found in more than 10 years of use. Sometimes a synthetic membrane will also be used to protect the bone graft. Some of these membranes need to be surgically removed at a later date.

\_\_\_\_\_ I have had an opportunity to discuss my past and current medical history including any serious problems and/or injuries with my doctors. I have disclosed any medications I am taking.

\_\_\_\_\_ I understand that I may be instructed not to wear my dentures for 2-3 weeks following implant placement. Compliance with this instruction is critical to successful implant treatment.

\_\_\_\_\_ Non-active duty beneficiaries are treated on a space available basis. I understand every effort will be made to provide one year of follow up after the implants are restored. After one year, I may have to seek further follow up care and maintenance with civilian dentists at my own expense.

Medication, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol and other drugs. 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 will not be able to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

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I understand the importance of cooperating completely with the recommendations of my doctors while I am under their care. Failure to do so could result in a less than optimum result. As dental implant treatment is sophisticated and expensive, I agree to be available for treatment and follow-up appointments as necessary. I also understand the need and importance of maintaining proper oral hygiene. Like natural teeth, if dental implants are not properly cared for daily they will lose supporting bone through disease and will need to be removed.

Additional information regarding my care: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I understand there is no warranty or guarantee as to the results or outcome of placement of implants and that my condition could actually become worse if the implant(s) fail. I certify that I have had an opportunity to read and fully understand the terms and words within the above consent to the operation and the explanation referred to or made and discuss the same with my doctor to my satisfaction.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature: Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature: Doctor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature: Witness

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## INFORMED CONSENT FOR ENDODONTIC SURGERY

Dear Patient:

You have the right to be informed about your diagnosis and proposed surgery so that you may make a decision whether to undergo the procedures after knowing the risks and hazards. This disclosure is not meant to frighten or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

## POSSIBLE COMPLICATIONS OF ALL SURGERIES

Certain inherent and potential risks in any treatment plan or procedure exist, and in this specific instance such operative risks include, but are not limited to:

1. Swelling, skin discoloration, and pain can occur with any surgery and vary from patient to patient and from one surgery to another.
2. Trismus is limited opening of the jaw due to inflammation and/or swelling in the muscles. It is most common with impacted tooth removal, but can occur with almost any surgery.
3. Infection is possible with any surgical procedure and may require further surgery and/or medications if it does occur.
4. Bleeding is usual for most surgeries and can be controlled by following the instructions on the post-operative instruction sheet. Significant bleeding can occur during or after surgery, but it is not common.
5. Drug reactions are possible from any medication given and could include nausea, rash, anaphylactic shock and/or death.
6. TMJ dysfunction, or improper function of the jaw joint, is rare, but may require treatment ranging from the use of heat and rest to further surgery.
7. Local anesthetic reactions are rare, but include pain, swelling, bruising, infection, nerve damage, idiosyncratic or allergic reactions, which could result in heart attack, stroke, brain damage, and/or death.
8. Numbness, tingling, or burning sensations in the lip, chin, and/or tongue for days, weeks, or rarely, permanently because of possible bruising or damage to the nerve which passes below the roots of the lower teeth.
9. Sinus opening which might require additional surgery and/or medications because of entry into the sinus during treatment of upper posterior root tips which lie next to the maxillary sinus.

## OTHER ADDITIONAL COMPLICATIONS

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Patient's name: \_\_\_\_\_

This is my consent for endodontic surgery to be performed by, or under the direction of:

Dr. \_\_\_\_\_ at \_\_\_\_\_

I understand that the purpose of the procedure/surgery is to treat and possible 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, periodontal (gum) disease, premature loss of teeth, and/or premature loss of bone. I have been informed of possible alternative treatment plans including, as an option, no treatment at all. I have been given no guarantee or assurance that the proposed treatment will be curative and/or successful to my complete satisfaction.

I understand that the surgical team will perform the following procedure:

\_\_\_\_\_

and administer the necessary anesthesia. I understand the doctor may discover other or different conditions which may require additional or different procedures than those planned. I authorize him/her to perform such other procedures which are advisable in his/her professional judgement. I consent to photography and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed.

I have read and/or discussed the preceding risks which may occur in connection with this procedure. I have been given the opportunity to ask any questions or request a more detailed explanation. I have had the opportunity to discuss with the doctor my past medical and health history including any serious problems, injuries, or allergies. I have been advised of medication, drug, or anesthetic complications such as drowsiness, lack of awareness and coordination, or lack of judgement which can be increased by the use of alcohol or other drugs; this I have been advised not to operate any vehicle or hazardous device while taking any such medications and/or drugs until fully recovered from their effects.

I have been given and understand sufficient information to give my consent to the above mentioned surgery.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature: patient/legally responsible person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature: counseling dentist

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature: witness

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## INFORMED CONSENT FOR PEDIATRIC DENTAL TREATMENT

We must obtain your consent before providing dental treatment to your child. Please read this form carefully and ask about anything you do not understand.

1. TREATMENT PROCEDURES: I hereby authorize Dr.(s) \_\_\_\_\_ to perform upon my child (or legal ward) the following dental procedures, including any necessary or advisable local anesthesia, x-rays, or diagnostic aids.

\_\_\_ Preventive treatment (tooth cleaning, polishing, topical fluoride, and application of plastic "sealants" to the grooves of the teeth.

\_\_\_ Removal of decay and placement of dental restorations (fillings) or crowns (caps).

\_\_\_ Treatment of missing teeth with dental prosthesis (plate) or space maintaining appliances. \*\*

\_\_\_ Removal of the following teeth: \_\_\_\_\_

\_\_\_ Treatment(s) of diseased, infected, or injured oral tissue as described: \_\_\_\_\_

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\*\* PLEASE NOTE: Space maintaining appliances may be advisable after tooth extraction to prevent potential shifting of teeth and subsequent deformities of the jaw. The responsibility for obtaining this treatment belongs to you, the parent or guardian. We want you to understand that the Navy is not responsible or obligated to replace teeth which must be removed or to provide space maintaining appliances for your child. Also, we cannot be responsible for future damages if you neglect to obtain this care in a timely manner.

2. BEHAVIOR MANAGEMENT: It is our intent that all professional care delivered in our dental facility shall be of the best possible quality we can provide for each child. Providing a high quality of care can sometimes be very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: 1) hyperactivity, 2) resistive movements, 3) refusing to open the mouth or keep it open long enough to perform the necessary dental treatment, 4) aggressive or physical resistance to treatment, such as kicking, screaming, and grabbing the dentist's hands or the sharp dental instruments.

All efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, and understanding within a reasonable period of time.

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

a. TELL-SHOW-DO - The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with the instruments on a model or the child's or dentist's finger. The procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

b. POSITIVE REINFORCEMENT - This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or prize.

c. VOICE CONTROL - The attention of a disruptive child is gained by changing the tone or

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increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.

d. MOUTH PROP - A rubber or plastic device that is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth. This device helps even a cooperative child by making it easier to keep the mouth open.

e. PHYSICAL RESTRAINT BY THE DENTIST - The dentist restrains the child from movement by holding down the child's hands or upper body, stabilizing the child's head between the dentist's arm and body, or positioning the child firmly in the dental chair.

f. PHYSICAL RESTRAINT BY THE ASSISTANT - The assistant restrains the child from movement by holding the child's hands, stabilizing the head and/or controlling leg movements.

g. PAPOOSE BOARD AND PEDI-WRAP - These are restraining devices for limiting the disruptive child's movement for necessary dental treatment. The child is wrapped in these devices and placed in a reclined chair.

h. SEDATION - Sometimes drugs are used to relax a child who does not respond to behavior management techniques or who is unable to comprehend or cooperate for dental procedures. These drugs may be administered orally, rectally, nasally, by injection, or as a gas-nitrous oxide and oxygen (laughing gas). The child does not become unconscious. Your child will not be sedated without you being further informed and obtaining your specific consent for such a procedure.

i. GENERAL ANESTHESIA - The dentist performs the dental treatment with the child anesthetized (put to sleep) in the hospital operating room. Your child will not be given general anesthesia without you being further informed and obtaining your specific consent for such a procedure.

3. This treatment plan and alternate methods (if any) have been adequately explained to me, along with the advantages and disadvantages of each. I am advised that although good results are expected, they cannot be guaranteed due to possible complications or circumstances beyond the control of the dentist and staff. I further acknowledge that there are risks associated with any dental or oral surgery procedures (including the administration of anesthesia and sedation). These include but are not limited to pain, swelling, bleeding, discoloration/bruising, nausea, vomiting, allergic reactions and infections. Severe or even life threatening complications have been reported with the use of drugs for sedation.

4. I also authorize the use of photographs, x-rays, and other diagnostic materials and treatment records for the purpose of teaching, research, and scientific publication.

5. I hereby state that I have read and understand this consent form, and that all questions have been answered in a satisfactory manner. I also understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

6. I further understand that this consent will remain in effect until such time that I choose to terminate it.

PATIENT'S NAME: \_\_\_\_\_

\_\_\_\_\_  
Date                      Signature: Parent/Guardian - relationship

\_\_\_\_\_  
Date                      Signature: Counseling dentist signature.

\_\_\_\_\_  
Date                      Signature: Witness

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## INFORMED CONSENT FOR PERIODONTAL SURGERY

Dear Patient:

You have the right to be informed about your diagnosis and planned surgery so that you may make a decision whether to undergo the procedure after knowing the risks and hazards. This disclosure is not meant to frighten or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

## POSSIBLE COMPLICATIONS OF PERIODONTAL SURGERY

Certain potential risks are inherent in surgical procedures and these include, but are not limited to:

1. Swelling, bruising, and pain can occur with any surgery.
2. Trismus, or a limited opening of the jaw is common.
3. Infection can occur and may require further surgery and/or medications.
4. Bleeding is usual for most surgeries and can be controlled by following the post-operative instruction sheet. Significant bleeding is not common.
5. Drug reactions are possible from any medication and could include nausea, rash, anaphylactic shock, and/or death.
6. TMJ dysfunction, or improper function of the jaw joint, is rare.
7. Local anesthetic reactions are rare, but could include pain, swelling, bruising, infection, nerve damage, idiosyncratic or allergic reactions, which could result in heart attack, stroke, brain damage, and/or death.
8. Numbness or tingling sensations due to possible nerve damage.
9. Sinus openings due to surgery involving the upper teeth.
10. Damage to other fillings and/or teeth during surgery.
11. Sharp ridges or bone splinters which may require further surgery to smooth.
12. Increased tooth looseness after surgery for a variable period of time.
13. Tooth sensitivity to sweets, hot, or cold after surgery for a variable period.
14. Shrinking of the gums as part of the healing process.
15. Tooth elongation and greater space between teeth after the surgery.
16. Resorbable and nonresorbable membranes for guided tissue regeneration may require early removal.
17. Bone grafts can result in varying degrees of success.

## OTHER OR ADDITIONAL COMPLICATIONS

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Patient's Name: \_\_\_\_\_

This is my consent for periodontal surgery to be performed by, or under the direction of

Dr. \_\_\_\_\_ at \_\_\_\_\_

I understand that the purpose of the surgery is to treat and possibly correct my diseased periodontal 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 my include, but are not limited to, the following: swelling, pain, infection, cyst formation, further periodontal disease, endodontic (dental pulp) disease, loss of teeth, and/or loss of jaw bone. I have been informed of possible alternative methods of treatment, including: no treatment, non-surgical treatment, other surgical treatment procedures, and extraction. I understand the prognosis (predicted outcome) for my teeth and gums with and without the proposed surgery.

I understand that the proposed therapy is for my periodontal disease and other dental treatment may be required for other existing dental conditions such as fillings, extractions, dentures, root canal treatment, etc. I further understand that this treatment is intended to control, not cure, my periodontal condition and that effective daily oral hygiene and maintenance care at regular intervals is needed after surgical treatment due to the episodic and recurrent nature of periodontal disease.

I understand that the surgical team will perform the following procedure(s):

\_\_\_\_\_  
\_\_\_\_\_

and administer the necessary anesthesia. I understand the doctor may discover other or different conditions which may require additional or different procedures than those planned. I authorize him/her to perform such other procedures which are advisable in his/her professional judgement. I consent to photography and X-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed.

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 re-treatment, or worsening of my present condition despite the care provided. This is particularly important to understand in the case of periodontal therapy where I acknowledge that I am responsible for the thorough daily removal of bacterial plaque from my teeth, and that the doctor's opinion that therapy would be helpful, and that a worsening of my condition could occur without the recommended treatment.

I have read and/or discussed the preceding risks which may occur in connection with this procedure. I have been given the opportunity to ask any questions or request a more detailed explanation. I have had the opportunity to discuss with the doctor my past medical and health history including any serious problems, injuries, or allergies. I have been advised of medication, drug, or anesthetic complications such as drowsiness, lack of awareness and coordination, or lack of judgement which can be increased by the use of alcohol or other drugs; this I have been advised not to operative any vehicle or hazardous device while taking any such medications and/or drugs until fully recovered from their effects.

I have been given and understand sufficient information to give my consent to the above surgery.

\_\_\_\_\_  
Date Signature: patient/legally responsible person

\_\_\_\_\_  
Date Signature: counseling dentist

\_\_\_\_\_  
Date Signature: witness

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## INFORMED CONSENT FOR ORAL SURGERY

Dear Patient:

You have the right to be informed about your diagnosis and planned surgery so that you may make a decision whether to undergo the procedures after knowing the risks and hazards. This disclosure is not meant to frighten or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

## POSSIBLE COMPLICATIONS TO ALL SURGERIES OR EXTRACTIONS

1. Swelling, bruising & pain: These can occur with any surgery and vary from patient to patient and from one surgery to another.
2. Trismus: This is a limited opening of the jaw due to inflammation and/or swelling in the muscles. This is most common with impacted tooth removal, but it is possible with almost any surgery.
3. Infection: This is possible with any surgical procedure and may require further surgery and/or medications if it does occur.
4. Bleeding: Although significant bleeding can occur during or after surgery, it is not common. Some bleeding is, however, usual for most surgeries and is normally controlled by following the post-operative instruction sheet.
5. Drug reactions: A reaction is possible from any medication given and could include nausea, rash, anaphylactic shock and/or death.
6. TMJ dysfunction: This means the jaw joint (temporomandibular joint) may not function properly and although rare, may require treatment ranging from use of heat and rest to further surgery.
7. Sinus involvement: Due to the proximity of upper teeth to the nerve (especially the upper back teeth) to the sinus, it is possible an opening may develop from the sinus to the mouth or that a root may be displaced into the sinus. A possible sinus infection and/or permanent opening from the mouth to the sinus could develop and may require medication and/or later surgery to correct.
8. Numbness: Due to the proximity of roots on lower teeth (especially wisdom teeth), it is possible to bruise or damage the nerve with removal of a tooth. Numbness, tingling or having a burning sensation could remain for days, weeks, or possible permanently.
9. Local anesthesia: Certain possible risks exist which, although uncommon or rare, could include pain, swelling, bruising, infection, nerve damage, idiosyncratic or allergic reactions, which could result in heart attack, stroke, brain damage and/or death.

## ALL TOOTH EXTRACTIONS

1. Dry socket: This is significant pain in the jaw and ear due to loss of the blood clot and most commonly occurs after the removal of lower wisdom teeth, but is possible with any extraction. This may require additional office visits to treat.
2. Damage to other fillings and/or teeth: Due to the close proximity of teeth, it is possible to damage other teeth and/or fillings when a tooth is removed.
3. Sharp ridges or bone splinters: Occasionally, after an extraction, the edge of the socket will be sharp or a bone splinter will come out through the gum. This may require another surgery to smooth or remove the bone splinter.
4. Incomplete removal of tooth fragments: There are times the doctor may decide to leave in a

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fragment or root of a tooth in order to avoid doing damage to adjacent structures such as nerves, sinuses, etc.

5. Intravenous sedation: If intravenous medication is used, soreness at injection site or along the vein may develop as well as some discoloration of the injection site.

OTHER ADDITIONAL COMPLICATIONS

\_\_\_\_\_  
\_\_\_\_\_

Patient's Name: \_\_\_\_\_

This is my consent for oral surgery to be performed by, or under the direction of

Dr. \_\_\_\_\_ at \_\_\_\_\_

I understand the surgical team will perform the following procedure(s):

\_\_\_\_\_  
\_\_\_\_\_

and administer the necessary anesthesia. I have been informed of possible alternative treatment plans, including as an option, no treatment at all. I understand the doctor may discover other or different conditions which may require additional or different procedures than those planned. I authorize him/her to perform such other procedures which are advisable in his/her professional judgement. I consent to photography and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed.

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 re-treatment, 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 could occur without the recommended treatment.

I have read and/or discussed the preceding risks which may occur in connection with this procedure. I have been given the opportunity to ask any questions or request a more detailed explanation. I have had the opportunity to discuss with the doctor my past medical and health history including any serious problems, injuries, or allergies. I have been advised of medication, drug, or anesthetic complications such as drowsiness, lack of awareness and coordination, or lack of judgement which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle or hazardous device while taking such medications and/or drugs until fully recovered from their effects.

I have been given and understand sufficient information to give my consent to the above surgery.

\_\_\_\_\_  
Date Signature: patient/legally responsible person

\_\_\_\_\_  
Date Signature: counseling dentist

\_\_\_\_\_  
Date Signature: witness

