DR.KATBAB DENTISTRY

EXPLANATION AND CONSENT TO DENTAL SURGERY

Print Name:_____ Tooth #_____

Blood Pressure: _____

Purpose of Treatment

Extractions are considered for: orthodontic reasons, severely decayed teeth, infected teeth, periodontally diseased teeth, impacted teeth or for the prevention of future infection or problems.

Potential Complications

The following is not a list of all the potential complications but it does cover the most common ones.

Bleeding: A small amount of bleeding is not unusual and should stop by applying firm pressure with gauze. More than this is unusual and will require attention. It may require future stitches or a surgical dressing.

Infection: The chances of post operative infection increase with smoking and poor oral hygiene. Should infection develop, it may require oral antibiotics or IV in a hospital setting, dressing the wound, or sometimes an incision and draining. Signs and symptoms of infection include severe pain, non-resolving swelling, foul odor, fever and chills.

Numbness: Surgery in the jaw is often close to the nerves and there is no test that can accurately predict where nerves lie in the gum or bone. Damage to the nerve can result in temporary or permanent changes in the sensation of the affected area. This includes numbness, tingling, painful sensations or a loss of taste sensation. While occurrences of such changes in the sensation are uncommon, very little can be done if they occur.

Fractures: Broken jawbones are a rare complication. The risk does rise with older patients and when the bone is severely resorbed. Should a fracture occur, wiring of the jaw or wearing of a splint or denture may be necessary.

Remaining Roots: Small pieces of the tooth root may remain in the jaw if decided that its removal would complicate the surgical outcome.

Sinus Problems: Surgery in the upper jaw may be complicated by the position of the sinus. Should a tooth or root be lodged in the sinus, future surgical procedures may be required to remove it. Opening of the sinus is also possible and may require medication or surgery to repair it.

Damage to Adjacent Teeth: Sometimes, an adjacent tooth or its supporting structures may be damaged. The chances of this are increased if the adjacent tooth is weak with a large filling or crown. Subsequent problems may necessitate a new restoration, root canal or extraction of the affected tooth.

Consent: I have read the above information and the dentist has explained the points that are pertinent to my case. I understand this information and that there is no guarantee given that the proposed treatment will be successful in correcting the condition. Prior to the surgery I may not be experiencing

any pain or problems and realize there is a risk of failure, relapse, elective re-treatment or worsening of the present condition despite care provided.

I understand that this Consent to Treatment form and the treatment provided as described above be governed by the laws of the Province of and I consent to the Courts of the Province of having exclusive jurisdiction to entertain any action, suit or proceeding in respect of, or in any way relating to, such treatment, whether based on alleged breach of contract or alleged.

Negligence in providing such treatment or on any other grounds whatsoever, and whether against the dentist(s) named in above or against any of his/her partners, associates, employees or staff.

I undertake and agree to not commence any action relating to such treatment, whether based on alleged breach of contract or alleged negligence in providing such treatment, or on any other grounds whatsoever, in any other legal jurisdiction outside of the Province of whether or not I may have a right to do so.

I acknowledge and understand that Dr. _____ has agreed to provide professional services for me conditional on this undertaking being given and honoured by me with regard to my declaring that the Province of has exclusive jurisdiction over any action, suit or proceeding and Dr. has made it clear that without my making this undertaking, he would not have agreed to provide treatment for me.

I confirm that I have discussed the estimated cost, future costs and method and terms of payment for the treatment described in above with Dr._____ and that I have agreed to make such, payment on the terms we discussed.

BY INITIALING HERE "_____ ", I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT AND THAT THE EXPLANATIONS REFERRED TO WERE IN FACT MADE TO ME AND THAT THE FORM WAS FILLED IN PRIOR TO TREATMENT. I ALSO CERTIFY THAT I WAS GIVEN AN OPPORTUNITY TO ASK QUESTIONS AND ALL OF MY QUESTIONS HAS BEEN SATISFACTORILY ANSWERED. BY SIGNING BELOW, I ACKNOWLEDGE MY UNDERSTANDING OF THE INFORMATION ABOVE AND THAT I AGREE TO PROCEED WITH TREATMENT AS PROPOSED.

Patient Name (Print):_____

Signature of Patient: _____
Or Signature of Parent of Guardian (or other person authorized to consent for patient)

Relationship of Person Signing to Patient: _____

Note: When a patient is a minor and/or is otherwise incapable of consenting to the treatment, the consent of a parent, guardian or substitute decision maker must be obtained.

Date: _____

Witness: In my opinion, the patient/parent/guardian appears able to understand the treatment proposed and the information provided concerning the treatment.

Signature of Witness: _____

Dentist: _____

Dr Signature: _____