

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

*This is my request and authorization for Dr. Vice & Associates to perform the following treatment/procedure/surgery.*

\_\_\_\_\_  
\_\_\_\_\_  
I understand the purpose of the procedure/surgery & alternative methods of treatment, if any.

I understand that there are inherent & potential risks in any treatment plan/procedure, and that in this specific instance such operative risks include, but are limited to:

***Please initial each statement as you read it.***

- \_\_\_ 1. Post-operative discomfort, bruising, swelling that may necessitate several days of home recuperation.
- \_\_\_ 2. Loss of clot (dry socket) causing delayed healing.
- \_\_\_ 3. Bleeding that may be prolonged.
- \_\_\_ 4. Injury to adjacent teeth, fillings, crowns, or bridge appliances.
- \_\_\_ 5. Post-operative infection requiring additional treatment.
- \_\_\_ 6. Restricted mouth opening or stiffness for several day or weeks.
- \_\_\_ 7. Decision to leave small piece of root in jaw when it's removal would require extensive surgery.
- \_\_\_ 8. Temporomandibular Joint (TMJ) problems that are already present or undiagnosed can be aggravated by any dental procedure.
- \_\_\_ 9. Breakage of jaw.
- \_\_\_ 10. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue on the side of operation; this may persist for several weeks, months, or in remote instances, permanently.
- \_\_\_ 11. Opening of the sinus (a cavity located above the upper teeth) requiring additional surgery.
- \_\_\_ 12. Other \_\_\_\_\_

I authorize the using of photographs or tissue specimens for teaching purposes and/or professional publication.

I consent to administration of local anesthesia as deemed by a representative of Drs. Vice & Associates to accomplish the proposed procedure.

I understand that the use of illegal drugs before or after surgery may be life threatening.

I understand no guarantee or assurance regarding the results of the proposed procedure during curative or successful can be given.

I have an adequate opportunity to ask questions regarding my treatment plan including any possible optional treatment & its potential risks & understand the contents of this form I sign w/o duress.

\_\_\_\_\_  
Patient's Signature (must be 18 yrs. Old)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Legal Guardian

\_\_\_\_\_  
Doctor