Greenwoods™
Dental & Surgical Centre

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INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA

1. This is my consent for _____ to perform the following treatment/procedure/surgery:

   _____

   _____ as previously explained to me, other procedure deemed necessary or advisable as necessary to complete the planned operation.

2. I understand that the nature of the procedure/surgery and that the purpose of the procedure/procedure is to treat and help correct my chief complaint. My doctor has advised me that if the condition persists without treatment or surgery, my present oral condition will probably worsen over time, and the risks to my health may include, but not limited to, the following: swelling. Pain, infection, cyst formation, periodontal (gum) disease and or premature loss of bone and teeth. I have been informed of possible alternative methods of treatment if any.

3. _____ has explained to me that there are normal side effects inherent in any oral surgery treatment/procedure and in this instance such side effects may include one, none or all the following:

   -Postoperative discomfort and swelling that may necessitate several days of home recuperation.
   -Postoperative bleeding that may be prolonged and require treatment.
   -Injury to adjacent teeth and fillings.
   -Stretching of the mouth which may result in cracking and bruising of the corners of the mouth.
   -Restricted mouth opening for several days
   -Decision to leave a piece of root in the jaw when its removal would require extensive surgery.
   -Bruising of skin or gums.
   -Delayed healing with accompanying pain.

4. There is also the remote risk of complications with this procedure/surgery. They include but are not limited to:

   - Breakage of jaw.
   - Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months or in rare instances, permanently.
   - Opening of the sinus (A normal cavity situated above the upper teeth) requiring additional surgery.

5. I consent to administration of such local anesthesia, intra-venous sedation as deemed by _____ and his/her designated Anesthetist to accomplish the proposed procedure.

6. I agree and understand that I am **NOT** to have **ANYTHING** to eat or drink for 12 hours prior to **Intravenous Sedation**. Eating or drinking will result in the cancellation of my surgery and the loss of my $100.00 deposit.

7. Depending on their strength, certain medications, drugs, anesthetic and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus I have been advised not to operate any vehicle, automobile. When intravenous sedation is given I understand and agree not to operate any vehicle for 24 hours after my surgery. I agree not to drive myself home after surgery and will have a responsible adult drive or accompany me home after my discharge from surgery.

8. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgement or for the procedures in addition to or different from those now contemplated, I request and authorize the doctors to do whatever he/she may deem advisable including, in cases of emergency, transport to the hospital.

9. 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 would occur sooner without the recommended treatment.

10. I have had an opportunity to discuss with _____ my past medical and health history including any serious problems and/or injuries.

11. Please leave all valuables watches necklaces and piercings at home. ALL jewelry from the belly button and up **MUST** be removed prior to surgery. Greenwoods Surgical assumes no responsibility for loss of possessions.

12. All dependent persons under 18 years of age **MUST** be accompanied by a parent or legal guardian who will be responsible for signing the necessary consent papers.

13. Please have a bath or shower prior to surgery. Contact lenses must be removed prior to surgery. All make-up and nail polish must be removed.

14. Please take your regular medication unless instructed by your surgeon with a small sip of water at the usual time, and bring all your medications in the original containers to your surgery appointment.

15. It would be to your benefit to refrain from smoking two days prior to your surgery and 3 days following your surgery.

16. 7 days' notice is required to cancel any sedation surgery, failure to give 7 days' notice will result in the loss of your $100.00 deposit.

17. I agree to cooperate with the recommendations of _____ while under his care, realizing that any lack of same could result in a less than optimum result, and I agree to attend any post-operative appointments when necessary.

Should you require any further information, please do not hesitate to call the office at 204-779-7779.

I _____ CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO READ AND
Patient Name/Guardian

FULLY UNDERSTAND THE TERMS AND RISKS VERSES BENEFITS OF THE PROPOSED SURGERY/OPERATION.

_____	_____	_____
Signature of Patient	Signature of Guardian (Relationship)	Date
_____	_____	_____
Signature of Witness	Printed Name of Witness	Date