LINCOLN PLACE DENTISTRY

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# Surgical Informed Consent

I hereby consent for Dr. Laura Herzig, DDS to treat me, or my dependent _____ and authorize the following procedure(s) or such additional procedures as are considered necessary on the basis of findings during the course of said procedure(s):

_____

_____

The following are the reasons why the above named surgery is considered appropriate:

_____

The following alternative treatment methods have been explained to me:

_____

I have also been advised as to the probable outcome if no treatment is provided for this condition:

_____

I consent to the following anesthesia and/or medications to be given at the time of surgery:

1. Local anesthetic
2. Local anesthetic with nitrous oxide/oxygen therapy

I understand that there are certain common inherent risks possibly associated with this surgery and anesthesia including, but not limited to:

1. Drug reactions and side effects
2. Post-operative bleeding, swelling, bruising, pain and discomfort
3. Post-operative weakness, possibly loss of time from work or school
4. Post-operative infection, delayed healing, bone inflammation
5. Sinus involvement possibly requiring additional treatment or surgery
6. Nerve injury within the lower jaw resulting in temporary, but possibly permanent numbness and/or tingling of the lower lip, gums or jaw
7. Bone fracture
8. Bruising or inflammation at the site of injection

I understand the risks of driving, operating hazardous equipment, and drinking alcohol while taking prescribed pain medication. I have been given the opportunity to ask questions regarding this treatment to clarify by understanding. I am aware that the practice of oral surgery is not an exact science and I acknowledge that no guarantees have been made to me with regard to the procedures listed above.

Signature of Patient or Guardian _____ Date _____

Laura Herzig DDS _____