DENTAL SPECIALTY CENTER
FALCON

INFORMED CONSENT FOR BIOPSY

Patient name *(please print)*: _____ **Date of birth:**_____

PURPOSE OF BIOPSY. I understand that my dentist has recommended that I undergo a biopsy involving partial or complete removal of the lesion in the area of _____. The purpose of the biopsy is to diagnose the lesion type. The diagnosis will determine what follow-up care, if any, is required.

ALTERNATIVE TREATMENT. The doctor has informed me of the importance of the biopsy. I understand that if I choose not to proceed with the biopsy that I risk the worsening of an undiagnosed problem which may impact my oral and general health. Consequences may include, but are not limited to persistence and possible growth of the lesion.

SURGICAL PROCEDURE. I understand that the biopsy may involve some, or all, of the following: Use of local anesthetic, oral or intravenous conscious sedation analgesics and sutures (*stitches*), and additional procedures during the biopsy which are not known to be needed at this time. I understand that diagnostic studies relating to my biopsy will be performed by other medical/dental professionals.

RISKS AND COMPLICATIONS of biopsy. I understand that the risks and complications associated with the biopsy include, but are not limited to *the need for additional surgery or referral to another specialist, scarring, allergic reactions to dental materials/medications/anesthetics, bleeding, swelling and/or infection, pain, bruising (including facial), tooth sensitivity, exposure of root surfaces (recession), exposure of gaps between the teeth, exposure of crown and bridge margins, temporary restriction of mouth opening, increased tooth mobility, possible altered or loss of sensation due to dental nerve damage* (*teeth, gums, lips, tongue, cheeks, face, palate), opening to the sinus requiring more treatment, return of the lesion to the same area, even when it appears to be totally removed.*

RISKS AND COMPLICATIONS OF LOCAL ANESTHETIC USE. I understand that the risks and complications associated with the use of local anesthetic include, but are not limited to: *nerve injury* resulting in *altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve, but in some cases may be permanent.*

I understand that during treatment, unknown conditions may modify or change the original treatment plan, such as discovery of changed prognosis for adjacent structures or teeth. I therefore consent to such additional or alternative procedures as may be required in the best judgment of the treating dentist.

PATIENT RESPONSIBILITY. I understand the necessity of maintaining good oral hygiene for better healing and that tobacco and alcohol products may negatively affect healing. I understand that I may need to return for follow-up appointments for an extended period of time, even if the biopsy report shows no evidence of pathology, and that if I don't schedule & keep appointments as instructed, that the lesion may return and pose a serious threat to my health.

INFORMED CONSENT. I certify that I speak, read and write English. My signature below indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to the biopsy. No guarantees have been made to me regarding the success of the biopsy. I have given a complete & truthful medical history, including all *medicines, drug use, pregnancy,* etc. All of my questions were answered to my satisfaction before signing this form.

_____ _____ _____
Signature of Responsible Party Date Patient's Name

_____ Relationship to Party *(if Responsible Party is not Patient)*