

SURGICAL EXPOSURE and/or BRACKETING OF IMPACTED TEETH

Patient's Name: _____

Date of Birth: _____

INFORMED CONSENT: This form memorializes the discussion I have had with my doctor regarding the *purpose, risks, benefits* and *alternatives* associated with **surgical exposure and/or orthodontic bracketing of an impacted tooth**. I have been informed that impacted teeth have the potential of causing *undesirable tooth movement, damage to the roots of neighboring teeth, cyst formation, infection* and *referred pain*. I have also been informed that this surgery is an elective procedure and that I am under no obligation to have this treatment performed. The information provided in this form and discussions I have had with my doctor are intended to help me make informed decisions about my surgery.

- **Surgical site & Diagnosis:** _____
- **Planned treatment:** _____
- **Alternative options (in addition to non-treatment):** _____

RISKS ASSOCIATED WITH THIS SURGICAL PROCEDURE: I have been informed of and understand that the planned treatment of **surgical exposure and/or bracketing** of one or more impacted teeth is not without risks. **Potential risks** related to this surgical procedure include but are not limited to:

- *Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots* that may result in tooth loss or the need for tooth repair
- *Loose tooth/teeth, damage to dental appliances, cracking and/or stretching of the corners of the mouth, cuts on lips/mouth, stress/damage/fracture to jaw & jaw joints (TMJ), difficulty in opening the mouth or chewing*
- *Allergic and/or adverse reaction to medications and/or materials;*
- *Nerve injury, which may occur from the surgical procedure and/or the delivery of local anesthesia, 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 over time but may be permanent.*
- The applied bracket may come off and need to be re-attached. The bracket, wire and /or fine chain attached to the braces to pull the tooth into position may cause irritation to the tongue, lips, or cheek areas;
- The impacted tooth might not move and may be left in place or may need to be removed (extracted);
- Changes of the appearance of the teeth;
- An opening may occur from the mouth into the nasal or sinus cavities.

ANESTHESIA:

I elect to have the following type(s) of anesthesia administered (*as indicated by my initials*):

_____ Local Anesthesia	_____ Nitrous Oxide (Laughing Gas)	_____ Oral Conscious Sedation
_____ IV Conscious Sedation	_____ Deep Sedation (General Anesthesia)	

LOCAL ANESTHESIA RISKS: Local anesthetic is used to numb the teeth & tissues to ensure patient comfort. Though generally very safe, side effects & complications can occur. My doctor has discussed with me the risks associated with local anesthetic administration and I understand that they include, but are not limited to the following:

- *Tenderness redness, irritation, facial bruising at the injection site*
- *Changes in heart rate*

- *Nerve & blood vessel injury; transient numbness in the lips, tongue, chin, gums, cheeks & teeth*
- *Tissue injury from biting/chewing numb tissues*

Uncommon side effects and complications of local anesthetics include: failure of local anesthetic to work effectively); infection at the injection site requiring antibiotics & further treatment; damage to surrounding structures such as *blood vessels, nerves & muscles*; dizziness; nausea/vomiting; increase/decrease in heart rate; allergic reaction; tingling sensation/numbness in the lips, tongue, chin, gums, cheeks & teeth, which is transient but on rare occasions may be permanent; local anesthetic overdose, broken needles requiring removal, seizures, heart & breathing complications that may lead to brain damage, stroke, heart attack (*cardiac arrest*) or death.

POST-OPERATIVE INSTRUCTIONS: I will follow all instructions given regarding use of antibiotics & medications & have been advised of risks associated with prescription pain medications (*drowsiness, potential for addiction & a lack of awareness & coordination*) – effects which may be intensified with the use of **alcohol, tranquilizers, sedatives, or other drugs**. I will not operate any vehicle/machinery until I have recovered from the effects of medications & drugs.

NITROUS OXIDE: I understand that if I choose to have surgical treatment performed under nitrous oxide sedation, that I will be given the opportunity to discuss the risks & benefits of these options with my doctor, including the additional fees involved & special post-operative considerations before signing a **separate consent form**.

ORAL SEDATION/IV SEDATION/GENERAL ANESTHESIA: I understand that if I choose to have surgical treatment performed under **oral conscious sedation** or **IV conscious sedation** or **general anesthesia** that I will be given the opportunity to discuss the risks & benefits of these options with my doctor, including the additional fees involved & special post-operative considerations before signing a **separate consent form**. I agree not to have anything to eat or drink (*other than a small sip of water to take my medications*) for at least six (6) hours prior to my procedure and agree to be accompanied by a responsible adult who will drive me to and from my doctor's office and stay with me until I have recovered adequately to care for myself. I understand the drugs given to me for this procedure may not wear off for 24 hours. During my recovery from anesthesia, I agree not to drive, operate machinery/devices, or make important decisions (*signing documents, etc.*). If I am sedated or under general anesthesia during the procedure, I authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

INFORMED CONSENT: I attest that my **medical history**, including all past & present **prescription & non-prescription medications, medical conditions, recreational drug use, pregnancy (if applicable), allergies & hospitalizations**, is current and accurate. I have informed my doctor of all past issues with local or general anesthesia. I have informed my doctor if I am being treated or have been treated in the past (*including the distant past*) with **bisphosphonates**. I understand that the use of **tobacco & alcohol** is detrimental to the success of my treatment. I agree to *follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, & keep all appointments*. I will contact this office right away if complications arise. I understand that follow up visits or care, additional evaluation, treatment or surgery, and/or hospitalization, at additional expense, may be required.

I have had ample opportunity to discuss & ask my doctor questions regarding this procedure & am satisfied with the **nature, purpose, risks, benefits & fees** associated with the planned procedure & treatment alternatives. I have carefully read & understood the contents of this form and I, the undersigned, being the patient, parent or guardian, consent to proceed with **impacted tooth exposure and orthodontic bracketing** and any other procedure decided upon to be necessary or advisable in the opinion of the doctor. No guarantees regarding the outcome of this procedure have been provided to me. I understand that each human body is different and despite excellent surgical technique, not all surgeries have a successful outcome. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.



Patient or Legal Representative Signature: _____ Date: _____

Print Patient or Legal Representative Name/Relationship: _____

Doctor: _____ Date: _____

Witness: _____ Date: _____