CONSENT TO TREATMENT

Following a discussion with my surgeon, I understand the following with regards to my treatment of -

1. **Inherent Risks:** oral surgery (which includes removal of teeth) has certain inherent risks. Those risks include, but are not limited to:

a) **Bleeding:** this normally subsides in a few minutes to a few hours. However, if it continues beyond that, in should receive immediate attention.

b) **Bruising:** and/or swelling may occur and last for few days or even a few weeks. This is especially true if impacted wisdom teeth are removed.

c) **Dry Socket:** occasionally this occurs after a tooth extraction and results from the blood clot not forming properly during the healing time.

d) **Infection:** while proper sterilization and cleanliness are carefully adhered to, the human mouth and oral cavity are inherently non-sterile environments. Infection can occur. Occasionally infection can result in swelling, fever, and feeling unwell. Attention should be received as soon as possible, especially if fever is present.

e) **Injury to adjacent teeth or filling:** no matter how carefully surgical procedure are performed adjacent teeth and filling (especially very large filling) can sustain injury.

f) **Fractured jaw, root fragments:** while rare, it is possible that the jaw, teeth roots, or bone may be fractured. A decision is then make on whether to perform future surgery or leave fragments in situ.

g) **Reactions to medication:** reaction to the medication, anaesthetic, or pain killers may occur. Reaction may also occur in response to any other medications that were administered or prescribed. Please keep us informed of any unusual symptom that may be associated with any of the above.

h) **For upper teeth. Sinus Involvement:** The tips of the roots of the upper teeth are very close to the sinus cavity in some patients. During extraction or other surgical procedures, the sinus can be perforated, and it maybe necessary to surgically repair it or retrieve roots that may have been displaced into it. This may require an onward referral to an oral surgeon department I hospital.

i) **For lower wisdom teeth. Nerve Injury:** There is a risk associated with the root tips and their proximity to the nerve supplying feeling to the lip and chin. The risks associated with damage to this nerve may include altered sensation, numbness, tingling and rarely pain. Where temporary is referred to, this may be up to 18 months in duration. Risk is assumed based on clinical and radiographic assessment with the evidence suggestion that:

   - Low risk = 2-5% temporary / 0.2-1% permanent
   - High risk = < 20% temporary <5% permanent

   A risk to the nerve supplying sensation to the tongue is 1-5%. This rarely includes affected taste.

2. **Complications**: Complications from dental procedures very rarely occur, but it is important to understand the possibilities both with and without treatment.

3. It is the patient's responsibility to seek attention should any problems arise after the treatment. In addition, the patient's responsibility is diligently follow all the pre-operative and post-operative instructions.
   If there is anything that you do not understand about the explanation, or if you want more information, please feel free to ask. A copy of this consent from will be kept with your notes.

   I am the patient and confirm that:
   - I have been fully informed of the nature of my condition and proposed treatment outlined above. Any likely complications of the treatment have been explained to me by the dentist named on this form.
   - I am aware of the alternative to the suggested treatment.
   - I have had opportunity to have my question answered.

I agree to:
- The administration of a local anaesthetics and use of materials and antibiotics as required.

I understand:
- That any procedure in addition to the treatment described in this form will be only be carried out if necessary and in my best interests and can be justified for medical reasons.

I have:
- Informed the dentist about my existing medical conditions and infectious diseases that are known to me.
- Had my wishes and needs considered.

PATIENT'S NAME: _____

SIGNATURE: _____

DATE: _____

SURGEON'S NAME: _____

SIGNATURE: _____

DATE: _____