INFORMED CONSENT FOR ORAL SURGERY AND ANESTHESIA

Please read BOTH PAGES of this informed consent carefully. After each paragraph the patient or guardian is 10 initial after reading.

Thus is ray consent For Dr. Bijan Afar to perform the following treatment/procedure/surgery/

I understand that the purpose of the procedure/ surgery is to treat and possibly correct may diseased oral and maxillofacial tissues. The doctor has advised me that if this condition persists without treatment or surgery my present condition may worsen in time, and the risks to my health may include, bur are not limited to the following, if any.

Dr Afar has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this case such operative risks include, but are not limited to the following:

1 Postoperative discomfort and swelling that may necessitate several days of home recuperation
2 Heavy bleeding that may be prolonged.
3 Injury to adjacent teeth, fillings, or caps.
4. Postoperative infection requiring additional treatment.
5 Stretching of the corners of the mouth with cracking.
6. Stiffness or tightness of the jaws for several weeks.
7 Deciding to leave a small piece of tooth root in the bone if its removal could injure adjacent teeth Or nerves.
8. Possible bone breakage (highly unlikely).
9 Injury to the nerve underlying the lower teeth resulting in loss of feeling of the lip. Teeth, Chin. Gums, or tongue on the affected side; this may persist for several weeks, months, or in rare c Permanently.
10. A fistula (hole) into the maxillary sinus requiring additional surgery.
11. If intravenous drugs are used, soreness and discoloration at the injection site.
12 Other

I consent to the administration of such local, inhalation, and intravenous medication as deemed by Dr Afar to accomplish the proposed procedure. If intravenous or inhaled drugs or 10 be used, I agree not to have anything to eat or drink for at least eight (8) hours prior to my surgical appointment

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, 1 have been advised not it. operate any vehicle, automobile, or hazardous devices, or work while taking such medication and drugs. 01 until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least 24 hours after rny release from surgery or until further recovered from I he effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me home after discharge from surgery.

I understand that there are inherent and increased risks with intravenous medications which could involve serious bodily injury, and that the proposed procedure could be completed painlessly with local anesthesia alone.

I agree not to use tobacco in any form for at least a week after oral surgery, realizing that to do so could increase the risk of complications and poor results.

I state that 1 have not used cocaine, crack, marijuana, or any other mind-altering drug for at least two weeks prior to my oral surgery.

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

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 difference there exists a risk of failure. relapse, selective re-treatment, or worsening of my condition despite the care provided.

I CERTIFY THAT I HAVE HAD AN OPPERTUNTTY TO READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT AND THE EXPUNATION REFERRED TO, AND THAT ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ANY INAPPLICABLE PARAGRAPHS WERE STRICKEN BEFORE I SIGHED. I ALSO STATE THAT : READ AND WRITE ENGLISH.

I AGREE TO BE RESPONSIBLE FOR ALL PAYMENTS DUE, INCLUDING COST OF COLLECTIONS.

Patient, Parent or Guardian

Date