

Anthony J. Hornaday, D.D.S.

Oral and Maxillofacial Surgery

620 S. Tillotson Avenue ♦ Muncie, IN 47304 ♦ (765) 289-9705

CONSENT FOR ORAL SURGERY

(pg 1 of 3)

Patient Name: <<patient_first_name>> <<patient_last_name>> Date: <<current_date>>

It is required that all patients read and sign consent prior to any treatment. In order for you to give your consent to treatment we feel strongly that you, as the patient, should be given as much information as possible regarding that treatment. We have found that our best patients are our most informed patients. This information is not meant to alarm you, but rather allow you to make an informed decision. We also feel that you should have an opportunity to ask questions and receive satisfactory answers to those questions. We ask that you please take your time and read the following form completely.

Dr. Hornaday has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance such risks include, but are not limited to, the following:

- A. Postoperative discomfort and swelling that may require several days of at-home recuperation.
- B. Prolonged or heavy bleeding that may require additional treatment.
- C. Injury or damage to adjacent teeth or fillings.
- D. Postoperative infection that may require additional treatment.
- E. Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly.
- F. Restricted mouth opening during healing; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.
- G. Injury to the nerve of the lower jaw resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue which may persist for several weeks, months or, in rare instances, permanently.
- H. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery or treatment.
- I. Allergic reactions (previously unknown) to any of the medications used in the procedure.

Regarding Biopsies:

If a biopsy is being performed, I understand that more than one procedure may be necessary in order to remove the entire lesion if it is not removed in its entirety during the first procedure.

Some lesions have a high reoccurrence rate and yours may reoccur and require additional operations months to years after the original surgery.

I understand that a scar may occur at the biopsy site requiring further care or surgery.

I understand that the tissue being removed will be sent to an outside oral pathology laboratory for a microscopic diagnosis and that there will be a separate fee for their services.

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Patient Name: <<patient_first_name>> <<patient_last_name>>

Date: <<current_date>>

I understand that Dr. Hornaday cannot be held responsible for the diagnosis rendered by the oral pathologist and that he will inform me if further treatment is necessary.

While performing my dental surgery I recognize that my doctor may discover other or different conditions than expected. This may require different or additional procedures than those planned or may, in my doctor's judgment, require termination of my surgery. I authorize Dr. Hornaday to perform such other procedures as he deems medically and/or surgically necessary in his professional judgment or to stop my procedure.

I understand that no warranties or guarantees of any kind have been made to me or anyone about the results of my surgery or procedure(s). I have been given adequate opportunity to read this entire form and to ask any questions about my surgery or procedure(s) before signing this form. I understand that it is my responsibility to inform my doctor if I wish to try another method of treatment to keep my tooth/teeth rather than undergo surgical intervention. I have been informed of the reason for my surgery, the risks involved, and possible alternate methods of treatment, if any, and I elect to undergo the treatment Dr. Hornaday has proposed.

I consent to the administration of anesthetics and medications as may be deemed necessary or advisable for my comfort, health, and safety. If general anesthesia is used, I understand that there may be soreness, redness, swelling, and/or bruising at or around the IV site or along the vein that may require additional treatment. Other rare complications of IV anesthesia may include allergic reaction to medications, respiratory problems that may require a breathing tube be placed, stroke, heart attack, heart failure, and/or death.

I am also aware that oral sedation, intravenous (IV) sedation, general anesthesia, and many drugs are not recommended for use for women who are pregnant. I understand that it is my responsibility (or the responsibility of a parent or legal guardian of a female patient) to advise my doctor if I am pregnant or possibly could be pregnant.

I also have been informed by Dr. Hornaday that antibiotics can and may interfere with the effectiveness of birth control and that I can and may become pregnant if another form of contraception is not used. I also understand and have been informed that if antibiotics are used in my care I will need to use another form of contraception and should consult my medical doctor.

I have been made aware that certain medications, drugs, anesthetics and prescriptions that I may be given can cause drowsiness, and lack of awareness and coordination which also may be increased by the use of alcohol and other drugs. I understand that I should not use alcohol, operate a vehicle or other hazardous machinery, or make any legal decisions while under the influence of any medication, anesthesia, or prescription given by this office. I have been advised not to return to work while taking such medications, or until fully recovered from the effects of such medications, drugs, anesthetics and/or prescriptions. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am given sedative medication for my surgery, I agree not to drive myself to the appointment or home afterwards and will have a responsible adult drive me to the appointment and home and accompany me until I am fully recovered from the effects of the sedation.

I understand that I will be asked to sign this consent form in a digital format and that the form I sign digitally is an exact duplicate of this form I just read.

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Patient Name: <<patient_first_name>> <<patient_last_name>>

Date: <<current_date>>

I certify that I have read and fully understand the terms and words in the above consent and /or any verbal explanations given to me by my doctor and/or his assistants, and that I give my consent voluntarily.

Patient or Legal Guardian Signature

Date: <<current_date>>

Witness Signature

Date: <<current_date>>



Doctor Signature

Date: <<current_date>>