

**Anthony J. Hornaday, D.D.S.**  
Oral and Maxillofacial Surgery  
Of East Central Indiana  
620 S. Tillotson Avenue ♦ Muncie, IN 47304 ♦ (765) 289-9705

CONSENT FOR ORAL SURGERY

Patient Name:

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 requiring restoration, root canal, or removal of the affected tooth/teeth.
- 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 underlying lower teeth 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 to any of the medications used in the procedure.

Patient \_\_\_\_\_ Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian/POA Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed By \_\_\_\_\_ Date \_\_\_\_\_

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.
- 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 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.

I also certify that if I am not the patient that I am the *legal guardian and/or power of attorney* for the patient for whom I am completing this form.

Patient \_\_\_\_\_ Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian/POA Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed By \_\_\_\_\_ Date \_\_\_\_\_