Park Family Dental

CONSENT TO ORAL & MAXILLOFACIAL SURGERY

Dear Patient:
You have a right to be informed about your diagnosis and planned surgery so that you may make a decision whether to undergo a procedure after knowing the risks and hazards. The disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so we may give an informed consent to the procedure. Please be assured that we will always do our best to make healing as rapid and trouble-free as possible.

POSSIBLE COMPLICATIONS (may be variable in occurrence):

*Please **initial** each paragraph after reading. If you have any questions, please ask your doctor before initialing.*

_____ ALL SURGERIES:

1. Soreness, pain, swelling, bruising, and 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 exists.
2. Bleeding, usually controllable, but may be prolonged and required additional care.
3. Drug reactions or allergies.
4. Infection and/or post-op fever; possibly requiring additional care, including hospitalization and additional surgery.

_____ ALL TOOTH EXTRACTIONS:

1. Dry socket (delayed healing) causing discomfort a few days after extraction requiring further care.
2. Damage to adjacent teeth or fillings.
3. Sharp ridges or bone splinters; may require additional surgery to smooth area.
4. Portions of tooth remaining - sometimes fine root tips break off and may be deliberately left in place to avoid damage to nearby vital structures such as nerves or the sinus cavity.

_____ UPPER TEETH:

1. SINUS INVOLVEMENT: Due to closeness of the roots of upper back teeth to the sinus or from a tooth root being displaced into the sinus, a possible sinus infection and/or sinus opening may result, which may require medication and/or later surgery to correct.

_____ LOWER TEETH:

1. NUMBNESS: Due to proximity of tooth roots (especially wisdom teeth) and other surgical sites to the nerves, it is possible to lose function of nerves following the removal of the tooth or surgery in the area. The lip, chin, teeth, gums, or tongue could thus feel numb (resembling local anesthetic injection). There may also be pain, loss of taste, and change in speech. This could remain for days, weeks, or possibly, permanently.
2. JAW FRACTURE: While quite rare, it is possible in difficult or deeply impacted teeth and usually requires additional treatment, including surgery and hospitalization.

_____ ANESTHESIA:

1. LOCAL ANESTHESIA: Certain possible risks exist that, although rare, could include pain, swelling, bruising, infection, nerve damage, and unexpected reactions which could result in heart attacks, stroke, brain damage, and/or death.

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PATIENT NAME: _____ I hereby authorize Dr. _____ and staff to perform the **following procedures:**

_____

_____

and to administer an anesthetic. I understand the doctor may discover other or different conditions that may require additional or different procedures than those planned. I authorize him/her to perform such other procedures as he/she deems necessary in his/her professional judgment in order to complete my surgery.

*Such alternative treatment methods to the surgical procedure(s) above described as are available to treat the aforesaid condition in my case were fully described to me prior to the time I executed this consent as witnessed by my signature and date below.

*I have discussed my past medical history with my doctor and disclosed all diseases and medications and drug use. I agree not to operate vehicles or hazardous machinery while taking prescription narcotic pain medications.

*I have received written postoperative instructions regarding home care, including emergency after hour phone numbers.

*I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following treatment, I agree to report them to the doctor or his/her designated agent as soon as possible.

*I have read and discussed the preceding with the doctor and believe I have been given sufficient information to give my consent to the planned surgery. It has been explained to me, and I understand that success of the aforesaid surgical procedure(s) and treatment is not guaranteed or warranted. No warrantee or guarantee has been made as to the results or cure. I certify that I speak, read, and write English and have read and fully understand this consent form for surgery; or if do not, I have had someone translate so that I can understand the consent form. All blanks were filled in prior to my initials and signature. I have been given the opportunity to question the above complications and understand.

_____ _____ _____

Patient's (or legal guardian's) signature **Relationship to Patient** **Date**

_____ _____

Witness signature Doctor's signature

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BISPHOSPHONATE/ RANKL Inhibitor/ Antiangiogenic drugs

INCLUDING, BUT NOT EXCLUSIVE TO:

- **Actonel** (Risedronate)
- **Aredia** (Pamidronate)
- **Bonefos** (Clodronate)
- **Boniva** (Ibandronate)
- **Didronel** (Etidronate)
- **Fosamax** (Alendronate)
- **Zometa** (Zoledronic Acid)
- **Reclast** (Zometa)
- **Prolia** (denosumab)
- **XGEVA** (denosumab)
- **Avastin** (bevacizumab)
- **Sutent** (sunitinib)

If you have **NEVER** taken BISPHOSPHONATE/ RANKL inhibitor/ antiangiogenic drugs please continue to **Section A**.

If you are **CURRENTLY TAKING** or **HAVE EVER TAKEN** BISPHOSPHONATE/ RANKL inhibitor/ antiangiogenic drugs continue to **Section B**.

A. I AM NOT, and have NEVER taken BISPHOSPHONATE/ RANKL inhibitor/ antiangiogenic drugs, INCLUDING, BUT NOT EXCLUSIVE TO: **Actonel** (Risedronate), **Aredia** (Pamidronate), **Bonefos** (Clodronate), **Boniva** (Ibandronate), **Didronel** (Etidronate), **Fosamax** (Alendronate), **Zometa** (Zoledronic Acid), **Reclast** (Zometa), **Prolia** (denosumab), **XGEVA** (denosumab), **Avastin** (bevacizumab), **Sutent** (sunitinib).

_____ _____ _____

Patient's (or legal guardian's) signature **Relationship to Patient** **Date**

STOP HERE if you have **NEVER** taken Bisphosphonate/ RANKL inhibitor/ antiangiogenic drugs.

If you are **CURRENTLY TAKING** or **HAVE EVER TAKEN** BISPHOSPHONATE/ RANKL inhibitor/ antiangiogenic drugs please proceed to **Section B**.

B. To be completed by any patient that **HAS EVER OR IS CURRENTLY TAKING** BISPHOSPHONATE/RANKL inhibitor/ antiangiogenic drugs INCLUDING, BUT NOT EXCLUSIVE TO**: Actonel** (Risedronate), **Aredia** (Pamidronate), **Bonefos** (Clodronate), **Boniva** (Ibandronate), **Didronel** (Etidronate), **Fosamax** (Alendronate), **Zometa** (Zoledronic Acid), **Reclast** (Zometa), Prolia(denosumab), **XGEVA** (denosumab), **Avastin** (bevacizumab), **Sutent** (sunitinib).

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Consent for dental treatment in patients who have received Bisphosphonate Drugs.

Please **initial** each paragraph after reading. If you have any questions, please ask your doctor **BEFORE** initialing.

Having been treated previously with Bisphosphonate/ RANKL inhibitor/ angiogenic drugs you should know that there is a significant risk of future complications associated with dental treatment. Bisphosphonate/ RANKL inhibitor/ angiogenic drugs appear to adversely affect the blood supply to bone, thereby reducing or eliminating its ordinary excellent healing capacity. **This risk is increased after surgery, especially from extraction, implant placement or other "invasive" procedures that might cause even mild trauma to bone. Osteonecrosis may result. This is a smoldering long-term, destructive process in the jawbone that is often very difficult or impossible to eliminate.** Your medical/dental history is very important. We must know the medications and drugs that you have received or taken or are currently receiving or taking. An accurate medical history, including names of physicians is important.

_____**1.** Antibiotic therapy may be used to help control post-operative infection. For some patients, such therapy may cause allergic responses or have undesirable side effects such as gastric discomfort, diarrhea, colitis, etc.

_____**2.** Despite all precautions, there may be delayed healing, osteonecrosis (dying bone), loss of bony and soft tissues, pathologic fracture of the jaw, oral-cutaneous fistula, or other significant complications.

_____**3.** If osteonecrosis should occur, treatment may be prolonged and difficult, involving ongoing intensive therapy including hospitalization, hyperbaric oxygen therapy, long-term antibiotics, and debridement to remove non-vital bone. Reconstructive surgery may be required, including bone grafting, metal plates and screws, and/or skin flaps and grafts. This may result in referral to a specialist at additional cost.

_____**4.** Even if there are no immediate complications from proposed dental treatment, the area is always subject to spontaneous breakdown and infection due to the precarious condition of the bony supply. Even minimal trauma from a toothbrush, chewing hard food, or denture sores may trigger a complication.

_____**5.** Long-term post-operative monitoring may be required and cooperation in keeping scheduled appointment is important. Regular and frequent dental check-ups with your dentist are important to monitor and attempt to prevent breakdown in your oral health.

_____**6.** I have read the above paragraphs and understand the possible risk of undergoing my planned treatment. I understand and agree to the following treatment:

_____**7.** I understand the importance of my health history and affirm that I have given all information that may impact my care. I understand that the failure to give true health information may adversely affect my care and lead to unwanted complications.

_____**8.** I realize that, despite all precautions that may be taken to avoid complications; there can be no guarantee as to the result of the proposed treatment.

_____	_____	_____
Patient's (or legal guardian's) signature	**Relationship to Patient**	**Date**