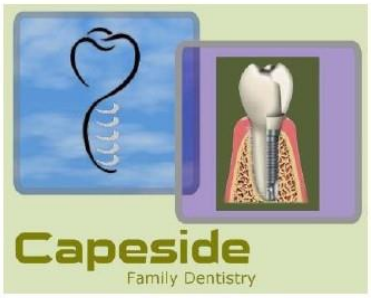

Samuel B. Artley, DMD, FAGD

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CONSENT FOR ORAL SURGERY

Please read, complete and sign this form carefully by indicating with your initial each page and complete signature at end of this form document.

You have the right to be informed about your condition and the recommended treatment plan to be used. This is so that you may make an informed decision as to whether or not to undergo the procedure; after knowing the wrist and hazards involved. This disclosure is not meant to alarm you but is rather an effort to properly inform you so that you may give or withhold your consent. It is our ethical and legal obligation to inform you on your condition(s), and any possible complication(s).

PATIENT NAME (print): _____ **DATE:** _____

1. I hereby authorize Dr. Samuel Artley, and any other staff, assistants or employees selected by him to assist and treat the condition(s) described as: _____.
2. The procedure(s) are necessary to treat the condition(s) and have been explained to me. I understand the nature of the procedure to be: _____.
3. I have been informed of any alternative methods of treatment (if any) including such treatment as: _____.
4. I understand that other forms of treatment or no treatment at all our choices that I have in the risk of those choices had been presented to me.
5. My doctor has explained to me that there are certain inherent and potential risks and side effects 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 and or dental restorations (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 for several days sometimes related to swelling, muscle soreness and stress on the joints of the jaw (TMJ).
G. The decision to leave a small piece of root in the jaw when it's removal would require extensive surgery or risk other complications.
H. Fracture of the jaw (in more complicated extractions).
I. Injury to the nerve underlying the 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.
J. Opening of the sinus; a normal cavity situated above the upper teeth requiring additional surgery.

Initials: _____

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K. A local inflammatory response of the tissues in and around the socket (dry socket), which may cause discomfort and may require daily medicated dressings to be applied. This treatment may be required of two several days depending on the symptoms.

L. Reactions to the medications prescribed including nausea, vomiting, and allergic and / or atypical reactions.

6. During the course of the procedure(s) unforeseen conditions may be revealed which will necessitate extension of the original procedure (s) or different procedure (s). I authorize the doctor and his staff to perform such procedure (s) as are necessary and desirable in the exercise of professional judgment.
7. I consent to the administration of_____ anesthesia in connection with the procedures referred to above.
8. I understand that certain medications, drugs, anesthetics and prescriptions which I may be given can cause drowsiness, in coordination and lack of awareness which also may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or hazardous machinery, and not to work while taking such medications, or until fully recovered from the effects of the same. I understand this recovery may take up to 24 hours or more after I have taken the last dose of the medication.
9. It has been explained to me, and understood fully, that a perfect result is not and cannot be guaranteed or warrantied.
10. Women only: I certify that I am not pregnant at the present time.
11. My signature below signifies that all questions have been answered to my satisfaction regarding the consent and I fully understand the risks involved for the proposed surgery and anesthesia. I certify that I speak, read, and write English and fully understand this consent for surgery.

*Please speak to your doctor if you have any questions concerning this consent form

PATIENT'S SIGNATURE: _____DATE:_____

WITNESS SIGNATURE: _____DATE:_____

DOCTORS'S SIGNATURE: _____DATE:_____

TRANSLATOR'S SIGNATURE: _____DATE:_____

Initials: _____