Park Family Dental

CONSENT TO BIOPSY

Dear Patient:
You have a right to be given pertinent information about your proposed surgery so that you may make an informed decision as to whether to proceed 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 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.

BIOPSY PROCEDURE:
A biopsy is a surgical procedure that requires a sample of tissue to be removed and sent to an oral pathology laboratory where it can be studied under a microscope. **The cost for the pathologist will be added to your treatment plan in addition to our surgical fee.** We prefer to take out all the suspected tissue. However, we may remove only enough tissue to get a good sample, leaving the rest behind. (This is usually done when the lesion is large, there is no cancer suspected, or the removal of all of it at this time would be unnecessarily difficult). If the biopsy report is suspicious of disease, we may need to go back in to take out more tissues to get a margin of safety.

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

1. _____ POSSIBLE COMPLICATIONS (may be variable in occurrence): I understand that a biopsy requires an incision in my mouth or on the skin in order to remove a sample of tissue. This tissue will be sent to an oral pathology laboratory where it can be studied under a microscope. This incision will require stitches and sometimes the removal of bone tissue. It has been explained that there are certain risks associated with the surgery including (but not limited to):

A. Postoperative discomfort and swelling that may require several days of staying home to recover.
B. Bleeding, usually controllable, but may be prolonged and may require additional care.
C. Infection and/or post-op fever; possibly requiring additional care, including hospitalization and additional surgery.
D. Stretching the corners of the mouth that may cause cracking and bruising, which may heal slowly.
E. Restricted mouth opening for several days, sometimes due to swelling, soreness, or stress in the jaw joints (TMJ).
F. Allergic reaction to medications, anesthesia, sutures, etc.
G. Injury to sensory nerve branches in the area of the biopsy which may result in pain, tingling or numbness in the lips, chin, tongue, cheek, gums, teeth, or areas of skin on the face. Usually this disappears slowly over several weeks or months, but occasionally the effects may become permanent.
H. If bone tissue is removed, healing may take longer and complications may be more likely.
I. There is always a possibility of the lesion recurring in the same area, even when it appears to be totally removed.
J. External scarring (ex. cheek or lip biopsies) may need further treatment by another specialist.

2. _____ 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.

3. _____ It has been explained to me that unforeseen conditions may be revealed which may necessitate an extension of the original procedure or a different procedure from that planned.

4. _____ 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.

(**Continued on the next page**)

5. _____ I understand that I may be given appointments for long-term follow-up care after my biopsy even if the biopsy report is benign. I recognize the importance of returning for follow-up care which, if not done, may allow progression of my condition to a state requiring additional care or further surgery, as the lesion may recur and become a threat to my health. I agree to comply by regularly scheduling exams as instructed and to notify the office if I suspect a change in my condition.

6. _____ 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.

7. _____ I understand that a sample of my tissue will be sent to an oral pathology laboratory for microscopic Study and it may take several days to get my results.

8. _____ I understand that there will be **2 separate fees** for this procedure, one for the surgical portion and one for the Oral Pathologist. I understand that Park Family Dental will pay the Oral Pathologist directly for their service and Park Family Dental will charge me and/or my insurance for both services. I understand that any quote given to me from Park Family Dental is strictly an estimate and may not be accurate. I understand that there are no guarantees that my insurance will cover either service. I understand that it is my responsibility to pay Park Family Dental for any costs that my insurance does not cover.

PATIENT NAME: _____ I hereby authorize Dr. _____ and staff to perform a biopsy procedure on the area of concern named below.

In your case, the area of concern is: _____.

***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 warranty 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