KEYSTONE ORAL SURGERY & IMPLANT CENTER

TOOTH EXTRACTION WITH GRAFTING AND ANTHESIA INFORMED CONSENT

Patient Name: _____
DOB: _____

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all of the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor is available to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

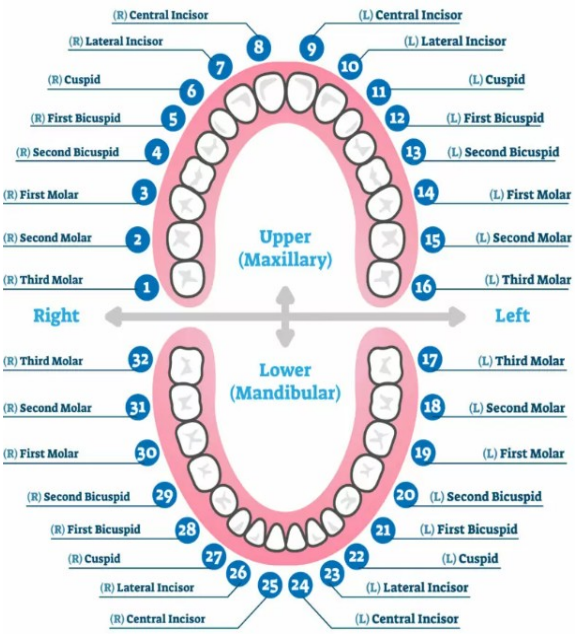


Diagram for illustrative purposes only. Teeth to be treated may be indicated on the diagram and/or described below.

Diagnosis: _____

_____

_____

Procedure: _____

_____

_____

Alternative options: _____

_____

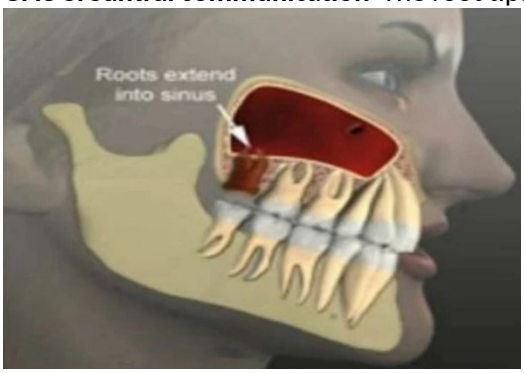
Other risks _____

I am been informed of and understand the **RISKS RELATED TO SURGICAL PROCEDURE** include but are not limited to:

1) **Pain, swelling, bleeding, infection, bruising, delayed healing, scarring**, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, retention of tooth structure, bone or foreign material in the body, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials

2) **Nerve injury**, which may occur from the surgical procedure and/or the delivery of local anesthesia, **resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste).** Such conditions may resolve over time, but in some cases may be permanent and/or require additional treatment. Part of the tooth and/or roots may be left to prevent damage to nerves or other structure

OAC oroantral communication The root tips of maxillary molars often extend into the sinus, a hollow chamber behind the cheekbones that helps lighten the skull. When these teeth are removed, an opening may occur from the mouth into the nasal or sinus cavities **OAC oroantral communication/hole in sinus causing regurgitation of food/air from mouth to nose** the dentist may need to surgically close the opening. Small exposures often heal on their own, but if the communication is large, a surgical procedure may be necessary to close it. **It's also very important to follow sinus precautions after surgery to promote healing and prevent complications.**



Patient's Initials _____

3) **Dry socket** (slow healing) resulting in jaw pain that increases a few days after surgery and Jaw fracture

4) Sharp ridges or bone splinters may form where the tooth was removed possibly requiring additional surgery. Failure of the bones to heal that may require further surgical treatment unable to achieve form and function

6) I understand that bone grafting may be necessary.

Bone Grafting: The graft will be taken from (anatomic location) or will be banked bone or bone substitute: _____The graft will be placed _____

I understand this **graft involves additional potential risks, including but not limited to**: Nerve injury at the place the graft was taken from or where the graft is placed resulting in altered or loss of sensation, numbness, pain, or changed feeling in the lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;

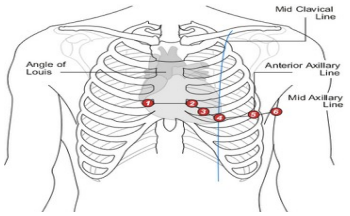
Failure, loss, infection, or rejection of the graft or membranes used to contain the graft;

If I have elected a banked bone or bone substitute graft, I understand there is a rare chance of disease transmission from the processed bone

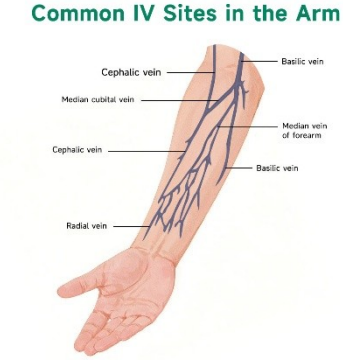
I Have elected to proceed with the anesthesia indicated below____Local Anesthesia ____Nitrous Oxide _____ Mild Sedation _____ Moderate Sedation _____ Deep Sedation (General Anesthesia)

MONITORING AND IV ACCESS

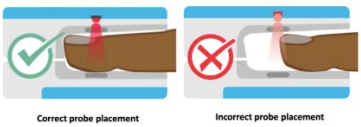
Heart (ECG) Monitoring: **Before and during anesthesia or sedation, adhesive ECG electrodes will be placed on the chest (and occasionally on the arms or legs) to continuously monitor heart rate and heart rhythm.** This monitoring is non-invasive and is performed to help ensure patient safety throughout the procedure.



Intravenous (IV) Line Placement:
If Mild, Moderate, or Deep Sedation (General Anesthesia) is selected, an intravenous (IV) line will be placed in a vein of the hand, wrist, or forearm prior to the start of anesthesia. The IV allows safe administration of medications, fluids, and emergency support if needed. The insertion site will be cleaned before placement, and the IV will be removed after the procedure unless medically necessary to keep it in place. Temporary pain, bruising, swelling, irritation, or numbness may occur at the IV site. Rarely, more serious complications may occur.
Note: For proper placement of ECG monitoring electrodes, patients are requested to wear short-sleeve or loose-fitting shirts on the day of the procedure. This allows safe and accurate monitoring during treatment.



Finger Pulse Oximeter – Nail Preparation: For accurate heart rate and oxygen monitoring, **please do not wear artificial (acrylic or gel) nails or nail polish on the finger used for monitoring,** typically the index finger. Artificial nails or nail products may interfere with the sensor and affect readings.



_____ I understand and consent to the placement of ECG monitoring electrodes and intravenous (IV) access as described above for my safety during anesthesia and/or sedation.

Patient's Initials _____

I have been informed of and understand the potential **RISK OF ANESTHESIA** include but are not limited to:

Pain, swelling, redness, irritation, numbness and/or bruising in the area where the IV needle is placed. Usually, the numbness or pain goes away, but in some cases, it may be permanent; Allergic or adverse reactions to medications or materials

Nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness. Some patients may have an awareness of some or all events of the surgical procedure after it is completed

Heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest) or death.

Sore throat or hoarseness if a breathing tube is used.

If I have elected Mild, Moderate, or Deep Sedation (General Anesthesia) I have not had anything to eat or drink for at least six (6) hours prior to my procedure. I understand that doing otherwise may be life-threatening. As instructed, I have taken my regular medications (blood pressure medications, antibiotics, etc.) and/or any medicine given to me by my doctor using only small sips of water. I am accompanied by a responsible adult to drive me to and from the doctor's office and he/she will stay with me after the procedure until I am recovered sufficiently to care for myself. I understand the drugs given to me for this procedure may not wear off for 24 hours. During my recovery from anesthesia, I agree not to drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

I have been informed of and understand that follow up visits or care, additional evaluation, treatment or surgery, and/or hospitalization may be needed

Patient's Responsibilities: _____I understand that a tooth extraction is an irreversible procedure.

_____ I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

_____I understand and accept the use of tobacco and alcohol is detrimental to the success of my treatment and will comply with my doctor's instructions.

_____I understand and agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications, risks, or less than optimal results.

_____I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, **I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.**

_____If I am sedated or under general anesthesia during the procedure, I further authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

Sinus Precautions You have either developed a communication between the maxillary sinus and your tooth socket or are at a high risk of developing one. We want to be certain that the tissues heal and that a communication does not become permanent. For this reason, we are recommending:

___ Do not smoke. Any smoking dramatically reduces wound healing and will make the process extremely difficult.

Patient's Initials _____

____Be sure to take the antibiotics we prescribed until they are gone.

____Avoid blowing your nose during the next four weeks and avoid any activity that increases pressure in your sinuses such as exercise or bending over/straining/sneezing. If you have to sneeze, do so with your mouth open. It is also important to avoid straws or suction.

____If your nose becomes very stuffy, you may use saline nasal spray twice a day for the next two weeks. Sudafed or Dimetapp for at least the next two weeks to reduce sinus congestion. A non-drowsy variety is recommended. This may be purchased at any pharmacy.

_____ Do not rinse your mouth too aggressively during these two weeks. Rinse gently. You can expect that there will be some bleeding from your nose as well as from your mouth for the next week. It is also possible that between the 7th and 14th day you may get a brief period of bleeding from the nose. This should take care of itself and require no treatment.

_____If you continue to get a feeling of water getting into your nose when you take a drink during the next few weeks, please call our office at **570-884-8321**

I certify that I explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained

Patient or Legal Representative Signature _____ Date _____

Witness to Patient Signature_____ **Doctor Signature**_____ **Date**_____

PATIENT ACKNOWLEDGEMENT REGARDING OPIOID USE

After surgery, pain may be treated with over-the-counter medications or, when necessary, prescription opioids. Use of opioid medication is voluntary.
I understand that opioids carry risks, including addiction, overdose, slowed breathing, and death. More information is available at **www.CDC.gov** and **www.FDA.gov**.
After discussing risks, benefits, and alternatives with my doctor, I agree to use a prescribed opioid for pain control. I understand lost or early-used medications may not be replaced.
I agree to:

- Take opioids only as prescribed
- Not exceed doses or share medication
- Avoid alcohol, sedatives, and other opioids not prescribed to me
- Report concerns and properly dispose of unused medication

I understand refills are provided only during normal business hours, and my doctor may review the Prescription Drug Monitoring Program (PDMP).

By signing below, I confirm that I understand and agree to the above.

Patient or Legal Representative Signature _____Date _____

Witness to Patient Signature_____**Doctor Signature**_____ **Date**_____

Patient's Initials _____