## ORAL SURGERY (If Planned)

I am informed and fully understand that inherent in any type of surgery, there are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling, bruising, discomfort, stiff jaws, and loss or loosening of dental restorations.

Less common complications include infection, loss or injury of adjacent teeth and soft tissue, nerve disturbances (e.g. numbness in mouth and lip tissues), jaw fractures, sinus exposure, and swallowing or aspiration of teeth restorations, or any type of material or elements used during the surgery, and small root fragments remaining in the jaw which might require additional surgery for removal.

I realize that even with the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and willfully permit all required diagnostic procedures.

I have had the opportunity to ask questions and receive both answers and detailed explanations for all questions about my medical/dental condition and have contemplated the alternative treatments and procedures, as well as all the risks and potential complications, prior to signing this form.

I have been made totally aware of the diagnosis associated with my condition and the proposed treatment options available.

I have had the material risks associated with treatment discussed with me and I recognize and accept these risks of treatment.

I have also had the likelihood of success of the proposed treatment discussed with me and understand the likelihood of success and the prognosis associated with the proposed treatment.

I understand the practical alternatives to the proposed treatment and I have been encouraged to review the proposed treatment as well as alternative treatment options with other reasonable and prudent dentists and physicians.

I have been made aware of the prognosis of my condition if the proposed treatment or alternative acceptable treatment options are rejected.

I give Goldstein, Garber & Salama, LLC, or any person, to whom they assign permission, to utilize photographs, video, or audio recordings for the purpose of education as well as the advancement of the field of dentistry.

| Patient Signature | Witness | Date |
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