MEDICAL PROTECTIVE
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CONSENT FOR ORAL PROCEDURE/SURGERY

As a patient, you have the right to be informed by Dr. ____________ (hereinafter, doctor) about your diagnosis, the recommended treatment, alternative treatments and associated risks/complications in order to best make an informed decision regarding your care. This form is designed as an aid in providing this information to you and encouraging you to become an active participant in your dental care.

DIAGNOSIS

_____I request and authorize Dr. ______________________________ and any other person under his direction or employee to treat the condition(s) described below:

____

____

PROPOSED TREATMENT

_____The recommended procedure(s) necessary to treat the condition/s named above have been explained to me. I have had the opportunity to ask questions and voice concerns, and I understand the answers and explanations. I understand the nature of the treatment to be:

____

____

____

TREATMENT ALTERNATIVES

_____While I understand the above treatment is recommended by my doctor , alternative treatment(s) for my condition may exist. I have been presented with information about these options, including the option to do nothing, in making an informed decision on my care:

____

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____

____

SAMPLE

This document should not be construed as medical or legal advice. Since the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney if you have any questions related to your legal obligations or rights, application of state or federal laws, contract interpretation or other legal questions that may potentially impact the applicability of the information provided in this document.
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RISKS AND COMPLICATIONS OF SURGICAL TREATMENT

______I understand that certain inherent and potential risks are associated with any treatment, and it's impossible for a dentist/oral surgeon to present and discuss all of the remote possible risks and complications. My doctor has presented the following to me and represented these to be the most probable complications of oral surgery:

______1) Postoperative discomfort, swelling and bleeding that may require a period of home recuperation;

______2) Postoperative infection that may require additional treatment including other surgical procedures;

______3) Stretching of the corners of the mouth with resultant cracking and bruising;

______4) Limited opening of the mouth and jaws during the postoperative period;

______5) Decision by the dentist or oral surgeon to leave portions of the tooth root in the jaw when its removal would increase your risks of complications and/or would require extensive surgery;

______6) Fracture of the jawbone;

______7) Injury to adjacent teeth, fillings, gum or bone, which could require additional procedures;

______8) Nerve injury resulting in a numbing or tingling of the chin, lip, tongue, cheeks, or gums that may persist for several weeks, months, or in remote instances, permanently;

______9) Opening of the maxillary sinus that does not close in the healing process. This condition would require surgery;

______10) Temporomandibular joint (TMJ) injury or aggravation of existing condition, which could require treatment including a surgical procedure;

______11) Other complications that may occur as explained by my doctor, including, but not limited to the following:

____

____

____

SAMPLE

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CONSENT FOR SEDATION/ANESTHESIA

I request and authorize Dr. ____ or his qualified designee, to administer the following for the performance of my surgical procedure:

_____Local anesthesia

_____Deep sedation/general anesthesia

_____For a minimal of six (6) hours prior to surgery, I agree that I will not or have not had anything to eat or drink.

_____I understand that medication, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination. The above symptoms may be increased by the use of alcohol or other drugs. My dentist or oral surgeon and/or his/her qualified designee has advised me that I should not work and cannot operate any vehicle or hazardous device for at least twenty-four (24) hours after surgery while I am under the effect of any pain medication.

SAMPLE

_____I understand that risks are present and associated with sedation and anesthesia procedures.
My doctor has explained the following associated complications, including but not limited to:

1) Inflammation of the vein or skin at the intravenous site.
2) Nausea and vomiting.
3) Respiratory difficulties.
4) Injury to the front teeth.
5) Eye injury.
6) Drug or allergic reaction.
7) Cardiac difficulties including cardiac arrest, which could possibly result in brain damage or death.

For questions, products or services, please contact 800/4MEDPRO or www.medpro.com
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SUMMARY

1) I read and understand English.	Yes	No
2) I understand that a perfect result is not guaranteed.	Yes	No
3) My condition or diagnosis has been explained to my satisfaction.	Yes	No
4) The proposed treatment has been explained to my satisfaction.	Yes	No
5) The treatment alternatives have been explained to my satisfaction.	Yes	No
6) The risks and complications associated with the surgery and sedation/anesthesia have been explained to my satisfaction..	Yes	No
7) I have had an opportunity to ask questions and have had them answered to my satisfaction.	Yes	No
8) I understand that unforeseen conditions may arise during the procedure that requires a different procedure than set forth above. I therefore authorize the dentist or oral surgeon to perform such procedures when, in there professional judgment, they are necessary.	Yes	No

SAMPLE

Patient or Legal Guardian (for minor) Signature Date

Witness Date

Dr. ____ Date

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