Aspen Springs Dental
7940 South University Blvd, Suite 200
Centennial, CO 80122
T. (720) 482-0793
F. (720) 482-0796

CONSENT FOR ORAL SURGERY

Name: _____Date:_____/_____/_____

I hereby authorize _____, and any other associates or employees, to perform the following procedures(s) upon me.

_____

_____

I have elected to have the above surgical procedure(s) performed under:

_____ Local anesthesia _____ Local anesthesia with nitrous oxide

I understand that there are certain risks associated with oral surgery, including (but not limited to):

- Post-operative discomfort and swelling
- Discoloration of the face and neck
- Bleeding which may be heavy or prolonged
- Injury to adjacent teeth and fillings
- Post-operative infection which may require additional treatment
- Stretching of the corners of the mouth that may cause cracking and bruising
- Restricted mouth opening for several days sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ)
- Decision to leave a small piece of root in the jaw when its removal would require extensive surgery or treatment
- Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, cheek, gums, tongue, or teeth. This is usually temporary for several months, but can be permanent.
- Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery
- Fracture of the bone
- A dry socket necessitating frequent post-operative care

I understand that no guarantees can be made and I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed surgery and anesthesia. I certify that I speak, read, and write English.

_____

Patient's (or legal guardian's) signature Date

_____

Doctor's signature Date

_____

Witness signature Date