



DAVID L. ROBERTS, DDS, PA

— General Dentist Providing Oral Surgery Services —

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DISCLOSURE & CONSENT—DENTAL & ORAL SURGERY

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and about the recommended surgical, medical, or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

I voluntarily request David L. Roberts, D.D.S., P.A. and such associates, technical assistants, and other healthcare providers as they may deem necessary, to treat my condition which has been explained to me as:

Non-restorable, periodontally-involved, and/or impacted teeth

I(we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me(us), and I(we) voluntarily consent and authorize these procedures under local anesthesia supplemental by: Nitrous Oxide IV Sedation Oral Sedation

Surgical extraction of teeth

I(we) understand that my doctor may discover other or different conditions which require additional or different procedures than those planned. I(we) authorize my doctor and such associates, technical assistants, and other healthcare providers to perform such other procedures which are advisable in their professional judgment.

I(we) understand that no warranty or guarantee has been made to me as to result or cure. I(we) have been given both oral and written post-operative instructions, and I(we) agree to personally contact Dr. Roberts in the event I(we) have a problem.

I(we) understand Dr. Roberts is not employed by my dentist but is an independent contractor and will receive a portion of the fee paid to my dentist for these services. I(we) have chosen Dr. Roberts from the alternatives I(we) have been offered to perform my dental surgery.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I(we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, pain, swelling, bleeding, bruising, allergic reactions, cardiac arrest, brain injury, and even death.

- 1. Temporary or permanent nerve injury resulting in altered sensations or numbness of the lips, chin, tongue, teeth, and/or gums.
2. Damage to adjacent teeth and/or dental restorations.
3. Soreness at injection sites and/or along veins, as well as discoloration of the injection sites, face, and/or jaws.
4. Opening of the sinus requiring additional treatment.
5. Jaw fracture, muscle spasms, and/or limited opening of jaws for several days or weeks.
6. Small root fragments remaining in the jaw due to an increased possibility of surgical complications.
7. Jaw joint (TMJ) tenderness, soreness, pain, or locking, which may be temporary or permanent.
8. Other

I(we) understand that IV moderate sedation ("twilight sleep") and other forms of supplemental sedation involve additional risks and hazards, but I(we) request the use of IV moderate sedation and/or other forms of supplemental anesthesia to assist in the relief and protection from pain during the planned and additional procedures.

I(we) understand that certain complications may result from the use of any IV sedative or other form of anesthesia, including respiratory problems, drug reactions, paralysis, cardiac arrest, brain damage, or even death. Other risks and hazards which may result from the use of IV sedation or other sedatives or anesthetics range from minor discomfort to injury of the vocal chords, teeth, and/or eyes.

I(we) have been given an opportunity to ask questions about my(our) condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I(we) believe that I(we) have sufficient information to give this consent.

I(we) certify this form has been fully explained to me(us), that I(we) have read it or have had it read to me(us), that the blank spaces have been filled in, and that I(we) understand its contents.

DATE: TIME:

Signature of Patient or Other Legally-responsible Person / Patient's Name (Please Print)

WITNESS: DATE: