Please read consent form. Signatures will be required at the office the day of your procedure.

INFORMED CONSENT FOR ORAL SURGERY AND LOCAL ANESTHESTIA

This is my consent for Dr. McCullom to perform the following treatment procedure/surgery:

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as previously explained to me, or other procedures deemed necessary to advisable to complete the planned operation.

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral/maxillofacial tissues. The doctor has advised that if this condition persists without any treatment or surgery, my present oral condition will probably worsen in time, and the risks to my health may include, but are not limited to the following: swelling, pain, infection; cyst formation; periodontal (gum) diseases; dental caries; malocclusion; pathological fracture of the jaw; premature loss of teeth; and/or premature loss of bone. I have been informed of possible alternative methods of treatment, if any.

Doctor McCullom has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to (check items applicable)

_____ 1. Postoperative discomfort and swelling that may necessitate several days of home recuperation.

_____ 2. Heavy bleeding that may be prolonged.

_____ 3. Injury to adjacent teeth and fillings.

_____ 4. Postoperative infection requiring additional treatment.

_____ 5. Stretching of the corners of the mouth with resultant cracking and bruising.

_____ 6. Restricted mouth opening for several days or weeks.

_____ 7. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.

_____ 8. Breakage of the jaw.

_____ 9. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side: this may persist for several weeks, months or, In remote instances, permanently.

_____ 10. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

____ 11. Other ____

_____ I agree and understand that I am not to have and/or have not had anything to eat or drink for 8 hours before my surgery.

_____ I consent to administration of such local and/or general anesthesia as deemed necessary by Dr. McCollom to accomplish the proposed procedure, with the exception of, _________________________, which I said I was allergic

_____ Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased using alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile or hazardous devices, or work, while taking such medications and/or drugs; until fully recovered from the effects of same. I understand and agree not to operate any vehicle or hazardous device for at least twenty-four (24) hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery.

_____ I understand that certain anesthetic risks, which could involve serious bodily injury, are inherent in any procedure that requires general anesthetic.

_____ If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he may deem available.

_____ No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful and that a worsening of my condition could occur sooner without the recommended treatment.

_____ I have had an opportunity to discuss with Dr. McCollom my past medical and health history including any serious problems and/or injuries.

_____ I agree to cooperate completely with the recommendations of Dr. McCollom while I am under his care, realizing that any lack of same could result in a less than optimum result.

I certify that I have had an opportunity to read and fully understand the terms and words within the above and consent to the operation. All blanks or statements requiring insertion or completion were filled in and applicable paragraphs. If any were stricken before I signed. I also state that I read and write English.

Dr. Cornell McCullom

Main Office: (773) 488.3738