FACIAL & ORAL SURGERY ASSOCIATES
CONSENT FORM FOR SURGERY

This is my consent for Dr._____ or any physician who may be employed by them to perform the surgery indicated below, and any other procedure deemed necessary or advisable as a corollary to the planned operation, I also agree to the use of a local and/ or ultra light general anesthetic, sedation and analgesia depending upon the judgment of the surgeon involved with my care.

I have been informed and understand that occasionally there are complications of the surgery, drugs and anesthesia including pain, infection, swelling, bleeding, discoloration, numbness and tingling of the lip, tongue, chin, gums, cheeks and teeth, pain and numbness and thrombophlebitis (inflammation to a vein) from intravenous and intramuscular injection, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reaction, bone fractures, bruises, delayed healing, sinus complications and nasal antral fistulas and openings. Certain possible risks attendant to sedation/general anesthesia, although uncommon, could include nerve damage to the arm, allergic or bruising at the injection site. Rare complications could include nerve damage to the arm, allergic or idiosyneratic drug reactions, pneumonia, heart attack, stroke, brain damage and/or death.

Medications, drug, anesthetics and prescription may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs; thus I have been advised not to operate any vehicle or hazardous devices, or work, while taking such medications and/or drugs or 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) hour or until further recovered from the anesthetic, medication and drugs that may have been given in the office for my care.

I acknowledge the receipt of and understand postoperative instructions and have been given an appointment date to return. The surgical procedure has been explained to me and I understand there is no warranty or guarantee as to any result and/or cure. I understand the possible risks attendant to the different phases of my care. Alternatives including, no treatment, have been outlined to me.

PROPOSED PROCEDURE: _____
_____
_____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Signature of Witness Date.