



ORAL SURGERY CONSENT FORM

Patient's Name: _____ Date: _____

1. I, the undersigned, hereby consent to Dr. Harry Sangha and his assistants performing the following procedure(s):

2. I acknowledge that the procedure(s), its implications and possible complications have been explained to me, along with the alternatives including not having any treatment.

3. I have been advised of possible complications of this procedure that are able to be reasonably anticipated, which are:

- Injury to a nerve, resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue to the operated side. This may persist for several weeks, months, or, in remote instances, permanently.
- Postoperative infection requiring additional treatment.
- Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
- Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint.
- Injury to adjacent teeth and fillings.
- In rare circumstances, breakage of the jaw.
- Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation.
- Decision to leave a small piece of root in the jaw when its removal requires extensive surgery.
- Stretching of the corners of the mouth with resultant cracking and bruising.

5. I acknowledge receiving a copy of the post-operative instructions, which have been explained to me. I understand all the advice given to me by my dentist. After my discharge, I will notify my dentist if I experience any acute pain, heavy bleeding from the surgical site, respiratory problems, or any other post-operative problems.

6. I understand that no guarantee can be given of the results of surgery on the human body, but that the doctor and office staff will do their best to achieve excellent results.

8. All my questions concerning this procedure have been answered to my satisfaction.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____