Dr. Mark Birnholtz DDS

Consent for the following Oral Surgery Surgical Procedure

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The oral surgery to be performed has been explained to me and I understand what is to be done. This is my consent to the oral surgery indicated on this form and to any other surgery deemed necessary or advisable in addition to the planned procedure.

I understand that occasionally there are complications of the surgery, drugs, and anesthesia. These complications may include, but not limited to; pain, infection, swelling, bleeding, and discoloration. Temporary or permanent numbness and tingling of the lip, tongue, chin, gums, and teeth are also possible with the removal of lower teeth. Damage to other restorations is also possible and often unavoidable. Stiffness of the facial muscles and changes in the occlusion or temporal mandibular joint may occur. There is also the possibility of injury to other tissues, referred pain to the ear, and head. Also possible are nausea, vomiting, allergic reactions, bone fractures and delayed healing. Sinus complications including a nasal fistula which is an opening into the sinus from the mouth may occur with the removal of upper teeth.

Alleviation of pain by removing a tooth is never guaranteed. I understand I can ask for and will receive a full recital or explanation of any and all possible risks attendant to my care by just asking.

Date_____ Patient Name_____

Patient or Responsible Party Signature_____

Witness Name and Signature _____