### CONSENT TO TREATMENT FORM

1. I authorize upon myself or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the following procedure(s) and treatments:
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or whosoever he/she may designate to perform such treatment. I also consent to such additional or alternative procedures that may be found immediately necessary during the course of such procedures or treatment.

 **SMILE LIKE YOU MEAN IT!**

1. The nature of and purpose of the treatment, possible alternatives methods of treatment, the risks involved and the possible complications have been explained to me by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_ as follows:

**ALTERNATIVES TO SURGERY**:

Risks to my health if these teeth are not removed include, but are not limited to:

1. Infection,
2. cyst of tumour formation,
3. periodontal disease, and
4. increased risk for complications if removal is required at a later time.

**POSSIBLE COMPLICATIONS**: which have been discussed with me include, but are not limited to:

1. pain and swelling,
2. injury to the nerves to the lower lip and tongue causing numbness, which could possible be permanent,
3. bleeding,
4. dry socket,
5. perforation of the sinus above the upper teeth,
6. infection,
7. decision to leave a small piece of root in the jaw when its removal would require extensive surgery and increased risk of complications,
8. injury to adjacent teeth or fillings,
9. unusual reactions to medications given or prescribed,
10. fracture of the jaw, and
11. trismus – limited jaw opening.
12. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.
13. I consent to the administration of such anesthetics as may be considered necessary or advisable by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
14. I agree to co-operate completely with Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_, and will follow postoperative instructions to the best of my ability for my own comfort and safety. I have had the opportunity to ask questions concerning these procedures.

I Certify that I have read and fully understand the above consent to treatment and that the explanations herein referred to were in fact made to me and that the form was filled in prior to treatment. I represent that I am eighteen (18) years of age or over and have read and understood the foregoing and I agree to be bound thereby.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (In my opinion, the patient appears to understand the treatment proposed.)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_