GENERAL INFORMED CONSENT FOR DENTAL PROCEDURES AND ANESTHESIA

This is my consent for Dr. Simpson or any other dentist or physician who may be necessary to perform the oral, maxillo-facial, and / or dental procedures indicated on my examination chart and any other procedure deemed necessary as a corollary to the planned sedation and / or ultralight general anesthesia depending upon the judgment of the doctors involved with my care.

I have been informed and understand that occasionally there are complications that can occur with any dental procedure including surgery, anesthesia, and / or medications. These include but are not limited to the following:

Postoperative discomfort and swelling
Heavy bleeding that may be prolonged
Postoperative infection requiring additional treatment
Bruising or discoloration at the injection site
Injury to the nerve underlying the teeth resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the treated site; this may persist for weeks, months, or in remote instances, permanently
Stiffening of the neck and facial muscles
Restricted mouth opening for several days or weeks
Thrombophlebitis (inflammation of a vein) from intravenous and intramuscular injections
TMJ injury secondary to treatment, especially when TMJ symptoms pre-exist
Change in occlusion
Injury to adjacent teeth, restorations in other teeth, and injury to other tissues
Referred pain to the ear, neck and head
Nausea and vomiting, allergic reaction, cardiovascular collapse or other conditions requiring hospitalization
Oral/sinus openings with delayed healing and possibly requiring additional surgery
Decision to leave a small piece of root in the jaw when its removal would require extensive surgery

Anesthetics, medications and prescriptions may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to operate any vehicle or hazardous device for at least 24 hours or until fully recovered from the effect of the anesthetic or medications that may have been given to e for y care.

During the course of treatment, unforeseen conditions may be revealed that necessitate an extension of the original procedure or a different procedure than first planned. I therefore authorize Dr. Simpson and any other necessary doctors and their assistants to perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.

All postoperative instructions will be explained to me along with receiving written instructions. I will arrange for a postoperative appointment visit if necessary and I understand that a perfect result or cure is not guaranteed or warranted and cannot be guaranteed or warranted. I also understand that I may ask for a full recital of all possible risks attendant to phases of my care by just asking.

____ ____________________
Patient / Parent Signature Date

____ ____________________
Office Representative Signature Date