JAMES R. PAYNE, DDS
— General Dentist Providing Oral Surgery Services —

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DISCLOSURE & CONSENT—DENTAL & ORAL SURGERY

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and about the recommended surgical, medical, or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you can give or withhold your consent to the procedure.*

I voluntarily request James R. Payne, DDS. and such associates, technical assistants, and other healthcare providers as they may deem necessary, to treat my condition which has been explained to me as:

Non-restorable, periodontally-involved, and/or impacted teeth_____

I(we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me(us), and I(we) voluntarily consent and authorize these procedures under local anesthesia supplemental by: ____ Nitrous Oxide ____ IV Sedation ____ Oral Sedation

Surgical extraction of teeth_____

I(we) understand that my doctor may discover other or different conditions which require additional or different procedures than those planned. I(we) authorize my doctor and such associates, technical assistants, and other healthcare providers to perform such other procedures which are advisable in their professional judgment.

I(we) understand that no warranty or guarantee has been made to me as to result or cure. I(we) have been given both oral and written post-operative instructions, and I(we) agree to personally contact Dr. Payne in the event I(we) have a problem. I(we) will follow his instructions until that problem has been satisfactorily resolved. I(we) realize that in the event I(we) develop certain complications, I(we) may miss school or work schedules or I(we) may incur additional, unexpected expenses, including, but not limited to, expenses for other dentists, doctors, or medical facilities.

I(we) understand Dr. Payne is not employed by my dentist but is an independent contractor and will receive a portion of the fee paid to my dentist for these services. I(we) have chosen Dr. Payne from the alternatives I(we) have been offered to perform my dental surgery. I(we) understand that Dr. Payne is a general dentist.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I(we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, pain, swelling, bleeding, bruising, allergic reactions, cardiac arrest, brain injury, and even death. I(we) also realize that the following risks and hazards may occur in connection with this particular procedure:

Patients: Initial items 1-8.

_____ 1. Temporary or permanent nerve injury resulting in altered sensations or numbness of the lips, chin, tongue, teeth, and/or gums
_____ 2. Damage to adjacent teeth and/or dental restorations
_____ 3. Soreness at injection sites and/or along veins, as well as discoloration of the injection sites, face, and/or jaws
_____ 4. Opening of the sinus requiring additional treatment
_____ 5. Jaw fracture, muscle spasms, and/or limited opening of jaws for several days or weeks
_____ 6. Small root fragments remaining in the jaw due to an increased possibility of surgical complications
_____ 7. Jaw joint (TMJ) tenderness, soreness, pain, or locking, which may be temporary or permanent
_____ 8. Other_____

I(we) understand that IV moderate sedation ("twilight sleep") and other forms of supplemental sedation involve additional risks and hazards, but I(we) request the use of IV moderate sedation and/or other forms of supplemental anesthesia to assist in the relief and protection from pain during the planned and additional procedures. I(we) realize the IV moderate sedation and/or other forms of supplemental anesthesia may have to be changed possibly without explanation to me(us). I(we) understand this is not general anesthesia (being completely asleep), and that it is unlikely, but I may have unpleasant memories of the procedure.

I(we) understand that certain complications may result from the use of any IV sedative or other form of anesthesia, including respiratory problems, drug reactions, paralysis, cardiac arrest, brain damage, or even death. Other risks and hazards which may result from the use of IV sedation or other sedatives or anesthetics range from minor discomfort to injury of the vocal chords, teeth, and/or eyes.

I(we) have been given an opportunity to ask questions about my(our) condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I(we) believe that I(we) have sufficient information to give this consent.

I(we) certify this form has been fully explained to me(us), that I(we) have read it or have had it read to me(us), that the blank spaces have been filled in, and that I(we) understand its contents.

DATE_____ TIME_____

_____ / _____

Signature of Patient or Other Legally-responsible Person / Patient's Name (Please Print)

WITNESS_____ DATE_____