Chestermere Smiles Dental
22 - 140 East Chestermere Drive
Chestermere, Alberta T1X 1M1
403.235.2282

Name of Patient: _____ Date: _____

1. This consent for Dr. _____ to perform the following treatment/procedure/surgery (specify any sedation): _____.
2. If any unforeseen condition should arise in the course of the operation, that, in the doctor's judgment calls for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever is deemed necessary or advisable.
3. I understand that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks may include, but are not limited to, the following:
    a. Postoperative discomfort, bruising, and swelling that may necessitate several days of recuperation
    b. Injury to adjacent teeth, crown or fillings
    c. Postoperative infection, dry socket, or delay in healing requiring additional treatment
    d. Restricted mouth opening for several days or weeks, discomfort in jaw joints
    e. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery
    f. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operative side: this may persist for several weeks, months or in rare instances, permanently
    g. Opening in the sinus (a normal cavity situated above the upper teeth) which may require additional surgery
    h. Breakage of the jaw
4. The nature and purpose of the treatment, possible alternative methods of treatment, the risks involved and the possible complications have been explained to me.
5. No guarantee or assurance have been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Because of individual patient differences, there exists a risk of failure, relapse or worsening of my present condition despite the care provided. Selective re-treatment may be needed. However, I accept the doctor's opinion that therapy would be helpful for my oral health, and that without treatment my oral condition may otherwise worsen with risks to my health including, but not limited to, swelling, pain, infection, cyst/tumor formation, periodontal (gum) disease, dental caries, malocclusion, pathologic fracture of jaw, premature loss of teeth, and/or premature loss of bone.
6. I have had an opportunity to discuss with the doctor my past medical history (including any serious problems/injuries) and any other concerns regarding the proposed treatment.
7. I agree to cooperate completely with the recommendation of the doctor while I am under his/her care, realizing that any lack of the same could result in a less than optimal result.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO TREATMENT, AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE IN FACT MADE TO ME, AND THAT THE FORM WAS FILLED IN PRIOR TO TREATMENT.

_____ Patient, Parent, Guardian

_____ Doctor

(over)

READ, REVIEW, SIGN…… THANK YOU

Instructions to Patients Following Oral Surgery

These instructions will be sent home with you at the end of your appointment on a small envelope together with some additional gauze. Please read, review, and then ask any questions you may have. Your signature below acknowledges your review of these instructions in advance. Thank you.

Instructions to Patients Following Oral Surgery

1. Bite on gauze for 30 minutes.
2. Keep fingers and tongue away from the operated area.
3. Do not rinse your mouth for 24 hours although it is permissible to drink cool or lukewarm liquids. Smoking should be avoided for 24 hours.
4. Starting tomorrow, rinse your mouth frequently with a solution of ½ teaspoon of salt in a glass of warm water. Continue these rinses for a few days.
5. If discomfort persists, please contact the doctor.
6. **Diet** – Cold or lukewarm liquids may be taken for the first 4 – 6 hours. After this, any soft food is permissible.
7. **Bleeding** – It is normal for saliva to be streaked with blood for a day. If frank bleeding is present, fold sterile gauze into a firm wad and place it directly on the bleeding area. Maintain firm pressure by biting for 20 minutes. The gauze may be substituted for a warm, soaked tea bag. The tannic acid in the tea has a clotting effect.
8. **Swelling and Discoloration** – is to be expected in certain areas, usually reaching its maximum two days after surgery. It will disappear gradually and is no cause for concern. If desired, ice pads may be applied for the first 4 – 6 hours only, alternating for 20 minutes on and 20 minutes off.
9. **Sutures (Stitches)** – If required, are removed without discomfort in about 5 days. An appointment will be made for you.
10. Do not hesitate to call the office if in doubt.

I have reviewed the above post-operative information today: _____
Date

_____ _____
Name (Please Print) Signature