

Informed Consent for Biopsy

Purpose of Biopsy: I understand that my dentist has recommended that I undergo a biopsy involving partial or complete removal of the lesion in the area of _____. The purpose of the biopsy is to diagnose the lesion type. The diagnosis will determine what follow-up care, if any, is required.

Choosing not to proceed: I was informed that if I choose not to proceed with the biopsy I risk the worsening of an undiagnosed problem which may impact my oral and general health. Consequences may include, but are not limited to, persistence and possible growth of the lesion.

Surgical Procedure may involve some, or all, of the following:

- Use of local anesthetic, oral or intravenous sedation, analgesics and sutures (stitches).
- Additional procedures during the biopsy which are not known to be needed at this time.
- Performance of diagnostic studies relating to my biopsy will be performed by other medical/dental professionals.

Risks and Complications of biopsy: I understand that the risks and complications include, but are not limited to:

- Need for additional surgery or referral to another specialist,
- Scarring,
- Allergic reactions to dental materials/medications,
- Bleeding,
- Swelling and/or infection,
- Pain and/or tooth sensitivity,
- Stress or damage to jaw joints (TMJ)
- Exposure of root surfaces (recession),
- Exposure of gaps between the teeth,
- Exposure of crown and bridge margins,
- Temporary restriction of mouth opening,
- Increased tooth mobility,
- Possible altered or loss of sensation due to dental nerve damage (teeth, gums, lips, tongue, cheeks, face, palate...).

Risks and Complications of local anesthetic use: I understand that the risks and complications associated with the use of local anesthetic include, but are not limited to: Nerve injury, which may occur from the delivery of local anaesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions usually resolve, but in some cases may be permanent.

Consent to Unforeseen Conditions: During treatment, unknown conditions, such as discovery of changed prognosis for adjacent structures or teeth, may modify or change the original treatment plan. I therefore authorize the treating dentist to do additional or alternative procedures if, in his/her professional judgment, it is in my best interest.

Compliance with Self-Care Instructions:

In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I understand the necessity of maintaining good oral hygiene for better healing and that tobacco and alcohol products may negatively affect healing.

Supplemental Records and Their Use: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of any and all procedures related to the completion of the biopsy as presented to me during the consultation and treatment plan presentation by the dentist.

Signature of Responsible Party

Date

Patient's Name

Relationship to Party (if Responsible Party is not Patient)

I confirm with my signature that I have discussed with the above-named patient the risks, potential complications, and intended benefits of the biopsy, as well as alternatives. The patient has had the opportunity to ask questions, all questions have been answered, and the patient has expressed understanding. Thus informed, the patient has requested that I perform a biopsy upon him/her.

Signature of Dentist

Date

Witness to Signatures Only

Date