

Informed Consent Surgical Exposure with Orthodontic Attachment

Diagnosis: Unerupted tooth/teeth _____

Purpose of Surgical Exposure with Orthodontic Attachment: I have been informed that the purpose of surgical exposure with orthodontic attachment is to provide access to the unerupted tooth can be moved into its proper position.

Alternative Treatment: The following alternatives to surgical exposure with orthodontic attachment have been explained to me:

- No treatment and long-term follow-up.
- Extraction (removal) and replacement with a prosthetic tooth (if necessary).

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

- Use of local anesthetic, oral or intravenous sedation, antibiotics, analgesics and sutures (stitches).

Risks and Complications of surgical exposure with orthodontic attachment: I understand that the risks and complications include, but are not limited to:

- Allergic reactions to dental materials/medications,
- Bleeding, swelling, infection,
- Pain,
- Temporary or permanent tooth sensitivity,
- Bruising,
- Scarring,
- Cuts inside mouth or on lips,
- Slow healing,
- Temporary restriction of mouth opening,
- Increased tooth/teeth mobility,
- Impact on speech,
- Gum recession on the tooth in question and neighboring teeth,
- Unaesthetic exposure of crown margins,
- Inadequate esthetic outcome which may necessitate additional treatment,
- Inadequate width of tough gum tissue which may necessitate future gum grafting.
- No movement of unerupted tooth following treatment (which may necessitate a secondary exposure procedure or extraction of the unerupted tooth),
- Possible altered or loss of sensation due to dental nerve damage (teeth, gums, lips, tongue, cheeks, face, palate, chin) including loss of taste which may resolve or time, but in some cases may be permanent.

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 may resolve, but in some cases may be permanent.

No Warranty or Guarantee: I understand that the doctor cannot guarantee the results of the procedure. I understand that there may be a need for a second procedure if the initial surgery is not satisfactory.

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.

PATIENT'S INITIALS _____

1

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 that trauma to the healing areas, smoking, medical conditions, clenching and/or grinding of teeth, dietary and nutritional problems, alcohol intake and medications I may be taking may affect healing and may limit the successful outcome of my surgery.

I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice good oral hygiene, keep all appointments, make return appointments if complications arise and complete care. I will inform my doctor of my past post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.

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 surgical exposure with orthodontic attachment 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 dental implants, 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 complete the surgical exposure with orthodontic attachment for him/her.

Signature of Dentist Date

Witness to Signatures Only Date