DENTAL PROFESSIONALS ON WHITESBURG
8315 Whitesburg Drive, S
Huntsville, AL 35802
256-883-6770

CONSENT FOR ORAL SURGERY

Name:_____Date:_____/_____/_____

I hereby authorize Dr. Sonya Wintzell and Dr. Lisa Bruce, and any other associates or employees of Dr. Wintzell, to perform the following procedures(s) upon me:

_____

_____

I have elected to have the above surgical procedure(s) performed under:

_____ Local anesthesia only _____ Local anesthesia with nitrous oxide

I understand that there are certain risks associated with oral surgery, including (but not limited to):

A. **Post-operative discomfort and swelling.**
B. **Bleeding which may be heavy or prolonged.**
C. **Injury to adjacent teeth and fillings.**
D. **Post-operative infection which may require additional treatment.**
E. **Stretching of the corners of the mouth that may cause cracking and bruising.**
F. **Restricted mouth opening for several days sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).**
G. **Decision to leave a small piece of root in the jaw when its removal would require extensive surgery or treatment.**
H. **Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, cheek, gums, tongue, or teeth.**
I. **Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.**

I understand that no guarantees can be made and I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed surgery and anesthesia. I certify that I speak, read, and write English.

_____

Patient's (or legal guardian's) signature **Date**

_____

Doctor's signature **Date**

_____

Witness' signature **Date**

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