Richmond Oral and Maxillofacial Surgery, LLC
1004 Oak Drive
Richmond, IN 47374
**(765) 935-1997**

# CONSENT FOR EXPOSURE AND BRACKETING OF IMPACTED TOOTH

**Patient Name:**_____**Date:**_____

It is required that all patients read and sign consent prior to any treatment. In order for you to give your consent to treatment we feel strongly that you, as the patient, should be given as much information as possible regarding that treatment. We have found that our best patients are our most informed patients. This information is not meant to alarm you, but rather allow you to make an informed decision. We also feel that you should have an opportunity to ask questions and receive satisfactory answers to those questions. We ask that you please take your time and read the following form completely.

Dr. Partridge, Hornaday, or Alderman has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance such risks include, but are not limited to, the following:

A. Postoperative discomfort and swelling that may require several days of at-home recuperation.

B. Prolonged or heavy bleeding that may require additional treatment.

C. Injury or damage to adjacent teeth or fillings requiring restoration or extraction of involved teeth.

D. Postoperative infection that may require additional treatment.

E. Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly.

F. Restricted mouth opening during healing; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.

G. Injury to nerves resulting in numbness or tingling of the chin, lip, cheek, gums, palate, and/or tongue which may persist for several weeks, months or, in rare instances, permanently.

H. Opening into the maxillary sinus (a normal cavity situated above the upper teeth) or nasal cavity requiring additional surgery or treatment.

I. Allergic reactions to any of the medications used in the procedure.

J. I understand that the brackets placed on the tooth or teeth can and may come off and require an additional surgery to replace them.

While performing my dental surgery I recognize that my doctor may discover other or different conditions than expected. This may require different or additional procedures than those planned or may, in my doctor's judgment, require termination of my surgery. I authorize Dr. Partridge, Hornaday, or Alderman to perform such other procedures as he deems medically and/or surgically necessary in his professional judgment or to stop my procedure.

Initials_____

I understand that no warranties or guarantees of any kind have been made to me or anyone about the results of my surgery or procedure(s). I have been given adequate opportunity to read this entire form and to ask any questions about my surgery or procedure(s) before signing this form. I understand that it is my responsibility to inform my doctor if I wish to try another method of treatment to keep my tooth/teeth rather than undergo surgical intervention. I have been informed of the reason for my surgery, the risks involved, and possible alternate methods of treatment, if any, and I elect to undergo the treatment Dr. Partridge, Hornaday, or Alderman has proposed.

I certify that I have read and fully understand the terms and words in the above consent and /or any verbal explanations given to me by my doctor and/or his assistants, and that I give my consent voluntarily. I also certify that if I am not the patient that I am the *legal guardian and/or power of attorney* for the patient for whom I am completing this form.

Patient_____ Patient's Signature _____Date _____

Parent/Legal Guardian/POA Signature _____ Date _____

Witnessed By _____ Date _____