Janet E. Stukalin, D.D.S.
General and Cosmetic Dentistry

Disclosure and Consent
Dental & Oral Surgery

To the Patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you can give or withhold your consent to the procedure.

I (We) voluntarily request Dr. Janet E. Stukalin and such associates, technical assistants and other health care providers, as they may deem necessary, to treat my condition which has been explained to me as:

Non-restorable, Periodontally Involved and/or Impacted Teeth

I (We) understand the following surgical, medical and/or diagnostic procedures are planned for me (us) and I (we) voluntarily consent and authorize these procedures:

Surgical Extraction of Teeth
Bone Graft
Guided Tissue Regeneration/Resorption

I (We) understand that my doctor may discover other or different conditions, which require additional or different procedures than those planned. I (We) authorize my doctor and such associates, technical assistants and other health care providers to perform such other procedures, which are advisable in their professional judgment.

I (We) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I (We) realize that common to surgical, medical and/or diagnostic procedures are the potential for infection, pain, swelling, bleeding, bruising, allergic reactions and even death. I (We) also realize that the following risks and hazards may occur in connection with this particular procedure.

_____ 1. Nerve injury resulting in altered sensations of the lips, chin, tongue, teeth and/or gums
_____ 2. Damage to adjacent teeth and/or dental restoration
_____ 3. Soreness at injection sites and/or along veins as well as discoloration of the injection sites, face and/or jaws
_____ 4. Opening of the sinus requiring additional treatment
_____ 5. Jaw fracture

_____ 6. Small root fragments remaining in the jaw due to an increased possibility of surgical complications
_____ 7. Limited opening of jaws for several days or weeks
_____ 8. Muscle spasms
_____ 9. Other: _____

I (We) understand that I.V. sedation involves additional risks and hazards, but I (we) request the use of I.V. sedation for the relief and protection from pain during the planned and additional procedures. I (We) realize the I.V. sedation may have to be changed possibly without explanation to me (us).

I (We) understand that certain complications may result from the use of any I.V. sedative including respiratory problems, drug reactions, paralysis, brain damage or even death. Other risks and hazards, which may result from the use of I.V. sedation, range from minor discomforts to injury of the vocal cords, teeth and/or eyes.

I (We) have been given an opportunity to ask questions about my condition. Alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved and I (we) believe that I (we) have sufficient information to give this consent.

I (We) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in and that I (we) understand its contents.

_____
Signature of Patient/Other Legally Responsible Person

Date: _____ Time: _____

Witness: _____ Date: _____