



ALLRED
COMPLETE HEALTH DENTISTRY®
DENTAL

Allred Dental
955 Boardwalk Suite 201
San Marcos, CA 92078

P: (760) 304-6455
jeff@allreddental.com
www.AllredDental.com

Oral Surgery Consent

I hereby authorize Dr. Allred to perform all procedures listed below. I have been informed that the risks to my health if this procedure is not performed include, but are not limited to pain, infection, cyst formation, loss of bone around teeth/implant causing their loss, and an increased risk of complications if surgery is postponed.

I have been informed of any possible alternative methods of treatment should any exist. Further, I understand that there are certain inherent and potential risks in any treatment or procedure, and that in this specific instance, such risks may include the following:

1. Postoperative discomfort and swelling that may necessitate several days of home recuperation.
2. Restricted mouth opening for several days or weeks.
3. Prolonged bleeding.
4. Nausea and vomiting (usually associated with medications prescribed for pain).
5. Postoperative infection requiring additional treatment.
6. Damage to adjacent teeth, fillings, and crowns.
7. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
8. Stretching of the corners of the mouth with resulting cracking and bruising.
9. Opening into the maxillary nasal sinus or nose requiring additional surgery.
10. Prolonged drowsiness.
11. Change in occlusion and temporal-mandibular joint difficulty.
12. Injury to the nerve underlying the teeth/implant site resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months, or in remote instances, be permanent.
13. Fracture of the jaw.

I consent to the administration of local anesthesia in connection to the procedure referred to above.

I certify that I have read the above and fully understand this consent for surgery, and that I understand that a perfect result cannot be guaranteed. If unexpected problems arise during the procedure, the doctor has my permission to do what is deemed necessary to correct the condition.

Drugs given at the time of surgery for sedative purposes or control of pain following the surgery may cause drowsiness and a lack of awareness or coordination. If instructed to do so, I will not drive or perform hazardous chores until I have recovered from the effects of these medications.

Patient Name

Signature

Date