1-1940 Bank Street, Ottawa, ON K1V 7Z8
P (613) 521-3939 | E info@shifadentistry.com

CONSENT OF ORAL SURGERY

PATIENT NAME: ____

This is my consent for **Dr. Syeda** to perform the following surgical procedure:

____

If any unforeseen condition should arise in the course of the operation, that if the doctor's judgment calls for the procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever is deemed necessary or advisable.

I understand that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such risk may include, but are not limited to the following:

a) Postoperative discomfort, bruising and swelling that may necessitate several days of recuperation.
b) Injury to adjacent teeth, crowns or fillings.
c) Postoperative infection, dry socket, or delay in healing requiring additional treatment.
d) Decision to leave a small piece of root in the jaw when it's removal would extensive surgery.
e) Injury to the nerve underlying the teeth resulting in numbness or tingling or the lip, chin, gums, cheek, teeth and/or tongue on the operative side. This may persist for several weeks, months or, in remote instances, permanently.
f) Opening of the maxillary sinus during extraction of upper teeth, which may necessitate additional surgery.
g) Breakage of the jaw.
h) Swelling and soreness of the injection site.

The nature and purpose of the treatment, possible alternative methods of treatment, the risk involved and the possible complications have been explained to me in consultation with **Dr. Syeda.**

Should I receive oral sedation, I understand that I agree to not operating any vehicle or hazardous devices for a period of 24 hours. I agree to have a responsible adult drive me to my appointment and accompany me home after my discharge.

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No guarantee or assurance had been given to me that the proposed treatment would be curative and/or successful to my complete satisfaction. Because of the individual patient differences, there exists a risk of failure, relapse or worsening of my present condition despite the care provided. Selective re-treatment may be needed. However, I accept the doctor's opinion that therapy would be helpful for my oral health, and that without treatment, my oral condition may otherwise worsen with the risks to my health including, but not limited to, swelling, pain, infection, cyst/tumor formation, periodontal (gum) disease caries, malocclusion, pathologic fracture of the jaw, premature loss of teeth, and/or premature loss of bone.

I have had an opportunity to discuss with Dr. Syeda and post medial and health history (including any serious problems and/or injuries) and any other concerns regarding the proposed treatment.

I agree to cooperate completely with the recommendations of the doctor while I am under her care, realizing that failure to do so could result in a less than optimal result.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO TREATMENT, AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE IN FACT MADE TO ME, AND THAT THE FORM WAS FILLED IN PRIOR TO THE TREATMENT.

Patient/Parent/Guardian ________________________________ Date _________________

Witness: