Dentistry & Orthodontics

A Smile 4 U Cartersville
509 N Tennessee St Ste 107
Cartersville, GA 30120

Ph : (770) 407-8700
Email: as4u_cv@asmile4u.com

Cora Neese
12 Russle Ridge
Euharlee, GA 30145

EXPLANATION OF SURGERY AND CONSENT FORM

TOOTH #:

The following conditions were explained by: Dr. and include:

In order to eliminate, correct, or improve the above conditions, surgical procedures will be necessary:

One or more of the following anesthetic or sedation techniques will be used in conjunction with your surgical procedure:
[ ] local anesthesia [ ] nitrous oxide sedation [ ] intravenous anesthesia

Listed below are some of the possible complications or risks of surgery. These are explained so patients will have a full understanding of their procedure.

1.Bleeding: anytime surgery is performed, a certain amount of bleeding is expected. However, unless the patient has some bleeding disorder, this is not usually a problem.
2.Damage to restorations or adjacent teeth. While the utmost care will be taken, the patient has to assume responsibility for replacement of restorations or tooth repair.
3.Damage to nerve fibers that go to the lower lip and tongue if the teeth lie near these nerves. This may result in numbness, possibly permanent to the teeth, gums, cheek, lower lip, chin and/or tongue.
4.Fracture of the lower jaw if a tooth is deeply impacted or the jaw is thin or weak.
5.Entry into the maxillary sinus in the case of some teeth whose roots are within the sinus.
6.Post-operative infection.
7.Symptoms of temporomandibular joint disease or disorder or exacerbation of pre-existing problems.
8.In addition to the above risks, there may be other risks attendant to performance of this procedure as with any dental, surgical or diagnostic procedure.

CHANGES IN TREATMENT:
I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions necessary.

I have had the above conditions explained to me and do consent to have the above listed procedures performed.

I have read the above statements and have received a copy (if requested), and recognize their importance in helping me with making my decisions. My signature indicates that I have read and understand this consent document.
I recognize that failures can occur for various reasons and complications can occur in any procedure. I hereby grant authority to the doctor in charge to administer such procedures that may be deemed necessary or advisable in the diagnosis and/or treatment. I also certify that the information I submitted in the health questionnaire is true and complete. In order to receive treatment, I contract that in the event of any difference or disagreement between the attending doctor and me, I will give that doctor the opportunity to resolve the problem.

The risks and benefits associated with the above-referenced dental treatment have been thoroughly explained to me. I understand there is no certainty that I will achieve the desired benefits and/or results, and no guarantee or assurance has been made to me regarding the outcome of such dental treatment. In authorizing the above referenced dental treatment to be performed, I understand that unforeseen conditions may occur during such treatment, which may necessitate a total change, extension or modification of the original treatment outlined above, or necessitate a different type of treatment than such authorized treatment set forth above. I therefore authorize and request that such treatment may be necessary and desirable in the exercise of my doctor’s professional judgment.

I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the extraction(s), I agree to report them to the office as soon as possible. In case of an acute emergency, and in the event you cannot reach this office, or we have not returned your call in a reasonable amount of time, please proceed to the nearest emergency room for medical attention.

Furthermore, I have been fully informed as to the nature of my dental treatment including other such care and treatment, along with the potential benefits, risks or side effects of such dental treatment, and the likelihood of achieving the desired results. I have been told that the success of the dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status. I have discussed all of the above with the doctor, and have had all of my questions answered to my satisfaction. I consent to treatment.

Signature of Patient, Parent, or Guardian ______________________________