I UNDERSTAND that dental treatment requiring ORAL SURGERY and/or SOCKET PRESERVATION and/or RIDGE AUGMENTATION procedures, which I desire to have performed, include certain risks and possible unsuccessful results or procedural failure. Even though care and diligence will be exercised in this treatment, there are no guarantees of desired or anticipated results, or of the longevity of the treatment. I AGREE to assume the risks, possible unsuccessful results or procedural failure associated with the treatment, including but not limited to the following:

_____(initials) I understand injury to the nerves of the lips, tongue, tissues in the floor of the mouth, and/or the cheeks, etc. can possibly happen. These potential nerve injuries can cause numbness, tingling, burning, and loss of taste. These symptoms may last a few days, or could last a few weeks or months. In very rare cases the symptoms can be permanent.

_____(initials) Bleeding, bruising, and swelling may happen during and after the procedure(s). Bruising may be prolonged after surgery. Slight bleeding may last several hours. However, should it persist, you must contact our office immediately, especially if you feel light-headed while standing.

_____(initials) In some cases, the root tips of upper teeth lie in close proximity to the tissues of the sinuses. During ridge augmentation, or surgical procedures, the thin bone and tissues surrounding the sinus may be perforated. Should this occur, I understand it may be necessary to have the sinus surgically repaired.

_____(initials) I understand no matter how carefully surgical sterility is maintained, it is possible, because of the existing non-sterile or infected oral environment, for infections to occur postoperatively. At times these may become serious. Should severe swelling occur, particularly accompanied with fever or a general feeling of being uncomfortable, I will contact the dentist/dental office to seek further treatment. In some cases, hospitalization and/or treatment with I.V. antibiotics may become necessary, and I also assume those risks.

_____(initials) There is a possibility, even though extreme care is exercised, that bone spicules or fragments may fracture off during the procedure, which may require referral to a specialist for treatment. A clinical decision may be made to leave small pieces of bone fragment in the jaw when its removal would require extensive surgery and/or risk of complications.

_____(initials) There are several types of materials that can be used for bone replacement. Some include: allografts that use tested, sterilized bone taken from cadavers, alloplastic materials that use a man-made synthetic substance that mimics natural bone, autografts that use bone from other parts of your own body, and xenografts that use processed bone taken from animals. The dentist has explained to me his/her recommendations of all such materials and I have chosen the material believed to be best suited for my particular condition.

_____(initials) Injury to adjacent teeth, fillings or porcelain crowns may occur no matter how carefully surgical procedures are performed. Fractured fillings or crowns may require replacement.

_____(initials) Because of the normal existence of bacteria in the oral cavity and due to a number of other unforeseen conditions, in some cases the tissues of the heart may be susceptible to bacterial infection transmitted from the mouth to the heart through the circulatory system. A condition called bacterial endocarditis (an infection of the heart) may occur which can result in damage to heart valves. If any heart problems are known or suspected (such as a heart murmur following rheumatic fever, existence of an artificial heart valve, cardiac damage following PhenFen use, etc.), the dentist must be informed prior to surgery.

_____(initials) Muscle or jaw soreness may be noticed following oral surgery and Ridge Augmentation. Pre-existing conditions affecting the jaw-joints (TMJ) may be aggravated by oral surgery. Clicking, popping, muscle soreness and difficulty opening may be noticed for some time following surgery. If such symptoms or conditions persist, you, the patient, should call our office. The patient must notify the dentist of any such pre-existing conditions prior to surgery.

_____(initials) Unusual reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It is important to take all prescription drugs according to the doctor's instructions. If you are a female on oral contraceptives, you must be aware that antibiotics can render those contraceptives ineffective. Caution must be exercised to utilize other methods of contraception during treatment.

_____(initials) It is my responsibility to contact the dentist and seek attention should any abnormal postoperative circumstances occur.

_____(initials) I will diligently follow any preoperative and postoperative instructions given me.

VOLUNTARY INFORMED CONSENT TO TREATMENT

As indicated by my initials above and my signature below, the doctor and dental team have given me the opportunity to read this document in its entirety and have allowed me to ask any and all questions pertaining to the procedure(s) above, their nature and purpose. They have also explained to me alternative forms of treatment and the risks of nontreatment. They have answered all my questions and concerns to my satisfaction with language I could understand. I voluntarily assume any and all possible risk, including risk of substantial harm, if any, which may be associated with any phase of this, or any unforeseen additional, dental treatment in hopes of obtaining the desired results for me, or for my minor child or ward. I also voluntarily assume the risk that the desired result may not be achieved. I have also been given the option to seek treatment from a specialist. No guarantees or warranties have been made to me concerning the results. Moreover, the fee(s) associated with these services have been explained to me, and I accept the financial responsibilities.

By signing this form, I am willingly, under no duress, giving my consent to allow and authorize the doctor, dental team members, and their associates, to render any treatment they believe necessary, appropriate, and/or beneficial to me, or my minor child or ward, including the administration and prescribing of any/all anesthetics and/or medications.

Patient's Name	Signature of Patient, Legal Guardian, or Authorized Representative	Date
Tooth Number(s)	Witness to Signature	Date
Healthcare Provider's Name	Signature of Healthcare Provider	Date

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