

REQUEST FOR ORAL SURGERY

- 1. I hereby request that Dr. Kristal Greniuk-Wioncek with such associates or assistants as they may designate to perform upon:

_____ (Myself or name of patient)

the following operation, treatment, or procedure and I consent to the administration of such anesthetics and agents as may be considered necessary or advisable:

_____ (State nature of operation, treatment or procedure)

- 2. The following information is presented to conform to the principles of "INFORMED CONSENT". Any surgical procedure or anesthetic may result in certain postoperative effects. Usually these effects are limited to swelling, discomfort, bleeding and, less frequently, infection. On rare occasions, unpredictable drug or anesthetic reactions may occur. Since the mouth is richly supplied with nerves, anesthesia or surgery always carries with it the possibility that numbness of the lip, chin and/or tongue may occur. This numbness usually is temporary but can be prolonged, and, although rare, can be painful or permanent. Other unlikely but possible occurrences include prolonged healing, injury to other teeth or fillings, broken jaw, sinus opening or infection, and injury to the ligaments and muscles of the jaw joint can be caused or aggravated by oral surgical procedures. The utmost care will be taken to minimize the possibility of these complications.

Initial _____

- 3. It has been explained to me that in preparation for, during and following any contemplated surgery procedure, conditions may be revealed that necessitate an extension of the originally contemplated procedure(s) or different procedure(s) and I, therefore, authorize Dr. Kristal Greniuk-Wioncek with such associates or assistants as they may designate to perform such procedures(s) as they, in the exercise of their professional judgment may dictate. I further give consent to the taking of photographs for educational purposes.
- 4. I have read and understand the above explanation and consent to the administration of anesthesia, the performance of the planned surgery, and other procedures which may be deemed necessary at the time of surgery.

Date: _____ Signed time: _____ a.m./p.m.

Signed: _____

(Patient or person consenting for patient)

Relationship: _____

Witness: _____

I further certify that I have discussed this consent verbally with the doctor, that I understand my treatment options, and that I have had the opportunity to have all my questions answered.

Initial: _____

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