

**INFORMED CONSENT  
ORAL AND MAXILLOFACIAL SURGERY  
AND ANESTHESIA**

You have the right to be informed about your diagnosis and planned surgery, reasonable treatment alternatives, their benefits and reasonable risks, and to make a decision whether to undergo or forego this treatment. This disclosure details possible complications, however rare, that are inherent in the treatment of your condition.

Please consider this form carefully, as its execution, along with your discussion with Dr. Crane, is a confirmation that you understand the nature and purpose of the treatment, known risks associated with the treatment, and feasible treatment alternatives; that you have been given an opportunity to ask questions; and that all of your questions have been answered in a manner satisfactory to you.

**ALL SURGERIES**

1. Soreness and pain, including pain radiating to the ear, teeth, neck and/ or head. Discomfort usually increases over the first week.
2. Swelling, bruising, difficulty chewing and/ or swallowing and restricted mouth opening (trismus) during healing.
3. Bleeding and oozing, usually controllable, but may be prolonged and require additional care. Hematoma formation.
4. Drug reaction or allergy.
5. Infection, possibly requiring additional care, including hospitalization and surgery; and may result in loss of graft materials
6. Stretching, cracking, laceration, ulceration and/ or burn of gums and soft tissues of the lips, tongue, mouth and throat.
7. Recurrence or persistence of a lesion, cyst, tumor or infection, requiring additional treatment.
8. Swelling and facial asymmetry. Cosmetic deformity. Rarely, facial weakness.
9. Excess scarring. Keloid formation. Poor / incomplete healing. These may require additional surgery, and may be permanent.
10. Nausea or vomiting. Bed-rest and sometimes medication may be required for relief.
11. Bone or soft tissue loss/ atrophy of bone which may preclude future dental reconstruction, including dental implant placement.
12. Osteomyelitis/ osteonecrosis of the jaw bones, which may require hospitalization, prolonged medical treatment, and/ or surgery.
13. Dry socket and delayed healing causing discomfort.
14. Deep gum pockets resulting in sensitivity of teeth and gums.
15. Loosening/ cracking of adjacent teeth, crowns and fillings.
16. Sharp ridges of bone and bone splinters, which may require additional surgery to remove bony sequestra and smooth the area.
17. Retained tooth fragments. Occasionally root tips separate and are deliberately left in place to avoid injury to nearby vital structures.
18. Incomplete healing which may undermine adjacent teeth.
19. Tattooing of the gums or mucosa.
20. Increase in temporomandibular joint (TMJ) disorder symptoms.
21. Changes in the bite/ occlusion.
22. Failure of uncovered/ bonded teeth to move/ extrude/ erupt. Separation of bonded appliances, require re-application.

**LOWER JAW SURGERY**

1. Numbness: Although rare, loss of sensory nerve function following tooth removal or surgery on the lower jaw is possible. The lip, chin, teeth, cheek, gums or tongue could thus feel numb (resembling an anesthetic injection). There may also be pain, loss of taste, other sensory alterations and change in speech. This could remain for days, weeks, or rarely be permanent. Muscle weakness is extremely rare.
2. Jaw Fracture: While quite rare, jaw fracture is possible in difficult or deeply impacted teeth, or in removing cysts and tumors of the jaw. This usually requires additional treatment, including surgery and hospitalization. Wiring the teeth together during the time of healing for jaw fractures will significantly reduce oral hygiene, which may lead to gum disease, bleeding gums, loosening of teeth and discomfort. Wires and/or bone plates used to treat fractures sometimes have to be removed after healing. Rarely fractures do not heal well, requiring additional surgery. This can affect your bite.

**UPPER JAW SURGERY**

1. Sinus involvement: Due to the close proximity of the tooth roots to the sinus and nasal cavity, a sinus or nasal cavity opening, displacement of a tooth root or implant into the sinus, or a sinus infection, may result from surgery of the upper jaw.

**ANESTHESIA**

1. Local Anesthesia: Although extremely rare, adverse reactions to anesthetics can occur, including pain, palpitations, swelling, bruising, infection, nerve damage, itching and rash. Rare reactions include heart attack, stroke, brain damage and/ or death.
2. Intravenous or General Anesthesia: Certain risks exist that, although uncommon, include nausea, vomiting, pain, swelling, inflammation, and / or bruising at the injection site. Extremely rare risks include nerve or blood vessel injury (phlebitis), allergic or unexpected reactions, laryngospasm, bronchospasm, pneumonia, heart attack, shock, stroke, brain damage and death.
3. Medications, drugs, anesthetics and prescriptions may cause drowsiness, disorientation, confusion and lack of awareness/ coordination, which would be increased by the use of alcohol or other drugs. Operating machinery, driving, using cutlery, handling flammable materials, and alcohol use should not be attempted within 36 hours of taking such medications.

**BIOPSY/ EXCISION OF TISSUE**

- 1. Biopsy involves removing all or a portion of a suspicious tissue for microscopic evaluation. This will require incision(s) and stitches. Occasionally a residual defect requires later repair; for instance, when an opening into a sinus does not close on its own.
- 2. The purpose of the biopsy is to identify the suspicious tissue, so that subsequent treatment can be determined. Further surgery may be required.

**FEMALE PATIENTS**

- 1. Although generally considered to be safe, data is lacking regarding the effects of surgery, local anesthesia and intravenous or general anesthesia on pregnant or nursing women, the developing fetus or child. Elective surgical procedures should be deferred until after childbirth and nursing has been discontinued. All care should be directed under the consultation of your primary physician and/or obstetrician.

**PATIENT NAME:** \_\_\_\_\_

**I hereby authorize Dr. M. A. Crane and the Woodlands Oral & Maxillofacial Surgery P.C. staff to perform the following procedure(s):**

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**and to administer anesthesia.** I understand that Dr. Crane may discover other or different conditions that may require additional or different diagnostic and therapeutic procedures from those planned. I authorize him to perform such other procedures, tests and administrations, as he deems necessary in his professional judgment, in order to complete my surgery.

I have discussed my past medical history with Dr. Crane, having disclosed and not omitted all diseases, conditions, past surgeries, medications, elixirs, remedies, tobacco, alcohol and drug use.

**If I am having intravenous or general anesthesia, I testify that I have NOT HAD ANY FOOD OR DRINK FOR SIX HOURS before my appointment. To do otherwise may be life-threatening. I agree not to operate mechanical or motorized equipment, drive, use cutlery, etc..., for the next 36 hours. A responsible adult will escort me home, and accompany me during this time period.**

I agree not to operate vehicles or mechanical equipment while taking prescription narcotic or sedative medications.

I have received written postoperative instructions regarding home care, including emergency after-hours contact information.

I understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following treatment, I agree to report them without delay to Dr. Crane.

**I have read and discussed the preceding with Dr. Crane, and believe that I have been given information sufficient to give my consent to the planned surgery. All my questions regarding this consent have been answered fully and to my satisfaction. No warranty or guarantee has been made as to the results or cure.**

I certify that I speak, read and write English, and have read and fully understand this Informed Consent for surgery, or, if I do not, I have had it translated so that I can understand the consent form.

All blanks were filled in prior to my initials and signature. This form is two-sided.

\_\_\_\_\_  
Patient's Signature (or Legal Guardian)

\_\_\_\_\_  
Date

**I certify that the matters set forth above were explained to the patient (and, if underage, his parent/guardian/ medical power of attorney), that the patient was given an opportunity to ask questions, and that all questions were answered in a satisfactory manner.**

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date