



Oral and Maxillofacial Surgeon
Dr. Ming Yu

General Dentist Performing IV Sedation and Surgery
Ryan Meers, DDS
Caleb Hanson, DDS

Consent for Oral Surgery Extractions

Patient's Name _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

Your diagnosis is: _____

Your planned treatment is: _____

Alternative treatment methods include: _____

Whether a procedure is easy or difficult, it is still a surgical procedure. All surgeries have some risks. They include the following and others: **(PLEASE INITIAL EACH SECTION)**

- _____ 1. Swelling, bruising, pain, possible infection that might need more treatment, and longer healing times.
- _____ 2. Changes in the bite or difficulty in opening the mouth because of stress on the jaw joint (TMJ) may happen.
- _____ 3. Possible damage to other teeth close to the ones being taken out (more often those with larger fillings or crowns), or other tissues of the face or mouth might be harmed.
- _____ 4. It is very rare that the bones in the jaw will break, but it is possible in cases where the teeth are buried very deep in their sockets. Possible hairline to complete bone fractures are possible.
- _____ 5. The place where the tooth was taken out could be very painful (may develop dry socket)
- _____ 6. Bleeding or oozing can often happen for several hours, but excessive amounts of bleeding is not common.
- _____ 7. Sharp ridges or bone splinters will likely form in the coming weeks after the surgery at the edge(s) of the hole where the tooth was taken out. These are bone spurs that typically work themselves, but will often be painful and sore until they fall out. If the bone spur(s) do not resolve on their own, you might need another surgery to smooth/remove it.
- _____ 8. The hole where the tooth had been might need more care, or small pieces of the tooth root might be left there to prevent damage to very important things like nerves or a sinus (a hollow place above your upper back teeth)
- _____ 9. The roots of the upper back teeth are often close to the sinus and sometimes a piece of the root can get into the sinus. An opening may occur from the sinus into the mouth that may need more treatment.
- _____ 10. Numbness, pain, or change feelings in the teeth, gums, lip, chin and/or tongue (including possible loss of taste). This is due to the closeness of tooth roots (mainly with wisdom teeth) to the nerves which can be injured or damaged. Usually the numbness or pain goes away, but in some cases it may be permanent.
- _____ 11. There may be a need to remove or cut into neighboring teeth in order to complete the surgery or if it gets damaged during the procedure. Under the doctor's best discretion, if there are other non-restorable or problematic teeth, I give the doctor the discretion to make the medical decision to remove those teeth.
- _____ 12. While rare, there may be instruments or cutting burs that gets lodged into the bone or mouth that may require additional surgery to remove. May be due to defect or stress in the drill, bur, and/or instrument.

CONSENT

I understand that my doctor can't promise that everything will be perfect. I have read and understood the above and give my consent to surgery. I have given complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature _____

Date ____/____/____

Doctor's Signature _____

Date ____/____/____

Near Me Dental

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Witness' Signature _____ Date ____/____/____

CONSENT FOR INTRAVENOUS SEDATION/ANESTHESIA _____ Patient Name

Please initial each paragraph after reading. If you have any questions about your proposed treatment, please ask your doctor BEFORE initialing or signing this form.

You have chosen intravenous sedation/ general anesthesia for your surgery, a common procedure that is considered quite safe. Nevertheless, any anesthesia carries some risks and the common ones known for intravenous anesthesia are noted below for your review before you consent to its use: (PLEASE INITIAL EACH SECTION)

- _____ 1. All reactions (previously unknown) to any of the medications used.
- _____ 2. Discomfort, swelling or bruising at the site where the drugs are placed into a vein.
- _____ 3. Vein irritation, called phlebitis, where the needle is placed into a vein. Sometimes this may progress to a level of discomfort where arm or hand motion may be restricted, or further medication or care may be required.
- _____ 4. Nausea and vomiting, although not common, are unfortunate side effects of intravenous anesthesia. Bed rest and sometimes medication may be required for relief.
- _____ 5. Intravenous sedation is a serious medical procedure and whether given in a hospital or office, carries with it the risk of brain damage, stroke, heart attack or death.

YOUR OBLIGATIONS:

- _____ 6. Because the anesthetic medication (including oral premedication/sedation) causes prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you to and from surgery, and stay with you for several hours until you are recovered sufficiently to care for yourself. Sometimes the effects of the drugs do not wear off for 24 hours.
- _____ 7. During recovery time (normally 24 hours), you should not drive, operate complicated machinery or devices or make important decisions such as signing documents, etc.
- _____ 8. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK for eight (8) hours prior to your anesthetic. TO DO OTHERWISE MAY BE LIFE-THREATENING!** (Note: If directed by your doctor, sips of water may be used to take regular medication or prescriptions given to you (i.e., pills for high blood pressure, diabetes, etc).
- _____ 9. Upon request of the doctor, you agree to have your blood drawn and tested (for infectious diseases) before or after any treatment/procedure. You give permission to release the results to Near Me Dental as soon as it is available. Costs of the blood test will be covered by Near Me Dental. You have the option to opt out of this consent and not initial it.

CONSENT

I have read and understand the above paragraphs and realize that intravenous sedation/general anesthesia carries with it certain serious risks. I request that intravenous anesthesia be used for my surgery. All my questions regarding this consent have been answered fully and to my satisfaction, and I fully understand the risks involved. I certify that I speak, read and write English.

Patient's (or legal Guardian's) Signature

____/____/____
Date

Doctor's Signature

____/____/____
Date

____/____/____

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Witness' Signature

Date

INTRAVENOUS SEDATION AND RESPONSIBLE ADULT

1.) I certify that I have not had anything to **EAT OR DRINK for eight (8) hours prior to my appointment** except, if applicable, a small sip of water to take needed medications (i.e., pills for high blood pressure, diabetes, etc.) Patients are to take all regular medication, unless instructed otherwise.

2.) **A responsible adult must accompany the patient to the office, remain in their car during procedure, & not leave the parking lot for any reason, but to drive the patient home after procedure.**

Please have this person consent that they understand this is required for today's procedure:

Driver Name: _____

Cell Phone # (____) ____ -- _____

Driver Signature: _____

Date: ____/____/____

3.) The accompanying adult should closely keep the patient under continuous observation for at least 3 hours following dismissal from the office. After 3 hours, observe the patient at least every 15 minutes for 2 additional hours.

4.) Patients under the age of 18 must be accompanied by a parent or guardian.

5.) The patient should not drive a vehicle or operate machinery for 24 hours following the anesthesia experience.

6.) If you have an illness such as a cold, sore throat, stomach or bowel upset, please notify the office.

7.) I wore loose fitting clothing with a short sleeve shirt and low heeled shoes.

8.) I have removed all contact lenses, jewelry, and dentures before surgery

9.) I have removed or did not wear any lipstick, excessive makeup, or nail polish on the day of surgery.

I certify that these statements are true and accurate. I designate the above mentioned adult to be responsible for me. I have instructed them that they are responsible for my transportation and well-being during and after surgery today.

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Patient/legal Guardian Signature

____/____/____
Date of surgery

Patient Name: _____ Age: _____ Date: ____/____/____

Patient referred for extraction of teeth under sedation due to:

- ☐ The complex nature of the tooth position in relation to critical anatomic structures requiring a full cooperative under sedation.
- ☐ Infected teeth that has been deemed difficult to get numbed under local anesthetic.
- ☐ Complex medical condition that requires placement of monitors under sedation.
- ☐ History of documented dental anxiety or dental phobia.

History of Present Illness:

Allergies:

Past Medical History:

Medication:

Past Surgical History:

Social History:

- ☐ Smoking _____ PPD _____ Yrs
- ☐ Alcohol Use _____ Yrs
- ☐ Recreational Drugs _____
- Females: ☐ Pregnant _____ months
- ☐ Breast Feeding

Additional Questions

- ☐ Osteoporosis _____
- ☐ History of H & N Radiation _____
- ☐ History of Bisphosphonates: _____
- ☐ History of H & N Cancer _____

Head & Neck Exam:

Comments:

Skin: ☐ WNL _____
CNS: ☐ WNL _____
Lymph Nodes: ☐ WNL _____
TMJ: ☐ WNL _____
Soft Palate: ☐ WNL _____

Buccal Mucosa
Tongue
Floor of mouth
Lip
Vestibule

Comments:

☐ WNL _____
☐ WNL _____
☐ WNL _____
☐ WNL _____
☐ WNL _____

Additional Comments:

Near Me Dental

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[illegible]

Anesthesia Record

Oral and Maxillofacial Surgeon
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Patient's Name _____ Date _____

Escort Present: ☐ Yes ☐ No Age: _____ Male/Female _____ Female Patients: Any chance of pregnancy? Y / N

Smoker: ☐ Yes ☐ No ASA Class I II III IV

Consent form signed: ☐ NPO _____ hrs Weight _____ lbs ÷ 2.2 = (_____ kg) Mallampati Class 1 2 3 4

Time

Anesthesia Start _____:_____ OP Start _____:_____ OP Finish _____:_____ Anesthesia Finish _____:_____

Pre-Op Vitals P _____ BP _____/_____ SaO₂% Conc _____ Resp _____

☐ Bite Block

Sedations: Monitors: ☐ Pulse Oxim. ☐ BP ☐ ECG

☐ Throat Pack

O₂ L/min _____ IV: _____ ga Location: _____ IVF _____ cc

Medications	Dose	Time	Dose	Time	Dose	Time	Dose	Time
☐ Midazolam	_____ mg	_____	_____ mg	_____	_____ mg	_____	_____ mg	_____
☐ Fentanyl	_____ mcg	_____	_____ mcg	_____	_____ mcg	_____	_____ mcg	_____
☐ Benadryl	_____ mg	_____	_____ mg	_____	_____ mg	_____	_____ mg	_____
_____	_____ mg	_____	_____ mg	_____	_____ mg	_____	_____ mg	_____
_____	_____ mg	_____	_____ mg	_____	_____ mg	_____	_____ mg	_____

Local Anesthesia

☐ Ancefl g for post op infection risk _____ carp ☐ Lido 2% w/ 1:100K epi

☐ Clindamycin 600 mg for post op infection risk _____ carp ☐ 3% Carbocaine

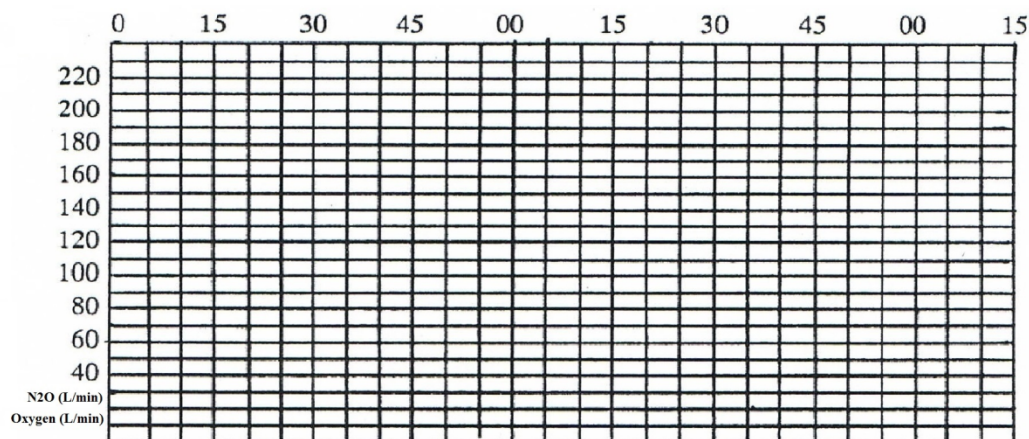
☐ Decadron 4 mg for postop swelling _____ carp ☐ 0.5% Marcaine w/ 1:100k epi

☐ Zofran 4 mg for postop nausea _____ carp ☐ 4% Septocaine w/ 1:100k epi

Pulse = λ

BP = $\frac{V}{\wedge}$

SaO₂ = x



Procedure: Doctor: _____ Staff: _____

Post Anesthesia/Discharge

Level of Consciousness ☐ Awake ☐ Responsive ☐ Non Responsive

Time of Discharge _____:_____ Post Op Instructions: ☐ Written ☐ Verbal

Condition: ☐ Responsive Ambulating ☐ w/o assistance ☐ w/ assistance

Discharge Vitals: BP _____/_____ Pulse _____ Resp _____ SaO2 _____