



**Mission Valley
Oral & Maxillofacial Surgery, Inc.**

**Fred W. Hammond, D.D.S.
Tim S. Smith, D.D.S.
Robert H. Riding, D.D.S.
Kenneth Spint, D.M.D.**

2878 Camino del Rio South • Suite 210
San Diego, CA 92108
619/ 298-2200 • Fax: 619/ 298-2250

MAXILLOFACIAL SURGERY CONSENT

You have the right to be informed about your condition and the recommended treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to provide information so that you may give or withhold your consent.

____ Patient's Name

____ Date

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

____ 1. My condition has been explained to me as: _____

____ 2. The procedure(s) necessary to treat the condition(s) has/have been explained to me and I understand the nature of the treatment to be: _____

____ 3. I have been informed of possible alternate methods of treatment (if any), including: _____

I understand that these other forms of treatment, or no treatment at all, are choices that I have and the risks of those choices have been presented to me.

____ 4. My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment and in this specific instance they include, but are not limited to:

- A. Post-operative discomfort and swelling that may require several days or more of at-home recovery.
- B. Prolonged or heavy bleeding that may require additional treatment.
- C. Injury or damage to adjacent teeth or fillings that may require additional treatment.





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- D. Post-operative infection that may require additional treatment.
- E. Stretching of the corners of the mouth that may cause cracking or bruising, and may heal slowly.
- F. Restricted mouth opening or joint pain during healing that may require additional treatment; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.
- G. A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
- H. Fracture of the jaw (usually only in more complicated extractions or surgery).
- I. Injury to the nerve underlying the teeth, resulting in pain, numbness, tingling, loss of taste or other sensory disturbances in the chin, lip, cheek, gums or tongue and which may persist for several weeks, months or, in rare instances, permanently.
- J. Opening of the sinus (a normal chamber situated above the upper teeth) requiring additional surgery or treatment.
- K. Dry socket (loss of blood clot from extraction site).
- L. Allergic reactions (previously unknown) to any medications used in treatment.
- M. Sharp ridges or bone splinters may form later at the edge of a surgical site. These may require another surgery to smooth or remove.

___ 5. It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph 2 above and/or change/addition of doctor. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

INFORMATION FOR FEMALE PATIENTS

___ 6. I have informed my doctor if I use birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my physician that I can return to the use of birth control pills.





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**BANKED BONE, (freeze-dried, lyophilized, demineralized, xenografts) OR BONE
SUBSTITUTES**

For ridge preservation after extractions, processed bone or artificial bone
substitutes may be used. If used, such materials may have separate risks including,
but not limited to:

___ 7. Rejection of the donated or artificial graft material – this is an extremely rare
complication.

___ 8. The remote chance of viral or bacterial disease transmission from processed
bone. This office only uses FDA approved graft materials which have a very
remote risk of disease transmission.

In this surgery, the following graft materials are planned to be used:

___ 9. Bovine bone Yes___/No___

___ 10. Human cadaver bone Yes___/No___

___/___

Yes No I have been given written preoperative instructions to follow before
my surgery and these have been reviewed with me to my satisfaction

___/___

Yes No I have been given written postoperative instructions to follow after
my surgery and these have been reviewed with me to my satisfaction

Patient's (or Legal Guardian's) Signature

Date





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Translator's Signature

Date

Doctor's Signature

Date

Witness' Signature

Date

I have been advised that my surgery will not be performed by Dr. _____, but by Dr. _____ and I give my consent for this change in providers.

Patient's (or Legal Guardian's) Signature

Date

