

Oral Surgery Consent & Information

THE FOLLOWING IS PROVIDED FOR OUR PATIENTS TO PROVIDE THE HIGHEST LEVEL OF INFORMED CONSENT.

Procedure is as planned:

I UNDERSTAND THAT THERE ARE CERTAIN RISKS ASSOCIATED WITH THE TREATMENT/TREATMENTS ABOUT TO BE PROVIDED. COMPLICATIONS MAY RESULT FROM THE USE OF DENTAL INSTRUMENTS, DRUGS AND ANESTHESIA. OTHER COMPLICATIONS MAY INCLUDE, BUT ARE NOT LIMITED TO: SWELLING, SENSITIVITY, BLEEDING, PAIN, INFECTION, TRANSIENT OR PERMANENT NUMBNESS, ALTERATIONS IN OCCLUSION, LOOSENING OF TEETH, DAMAGE TO ADJACENT STRUCTURES, FRACTURED ROOT TIP. I AGREE THAT TREATMENT IS BEING RENDERED AT THE HIGHEST STANDARDS, AND IS ALWAYS IN MY BEST INTEREST. IN THE EVENT OF ANY OR ALL COMPLICATIONS, I DO NOT HOLD DR. GALLAHER OR HIS STAFF RESPONSIBLE.

I UNDERSTAND THAT I MAY HAVE TO TAKE CERTAIN PRESCRIBED MEDICATIONS AFTER MY PROCEDURE, AND I AM TO ONLY FOLLOW THE DIRECTIONS PROVIDED TO ME BY DR. GALLAHER. I AM TO TAKE NO OTHER MEDICATIONS OR DRUGS UNLESS GIVEN PERMISSION BY DR. GALLAHER WHILE TAKING SUCH MEDICATION PRESCRIBED TO ME BY DR. GALLAHER FOR THIS PROCEDURE.

I UNDERSTAND THAT THERE ARE POSSIBLE OTHER TREATMENTS AND I HAVE BEEN COUNSELED ON ALL ALTERNATIVES.

PLEASE INFORM DOCTORS IF YOU ARE TAKING ANY OF THE FOLLOWING MEDICATIONS: FOSOMAX, BONIVA, OR ACTONEL.

Patient/Guardian

Date:

Kell Darren Gallaher, D.M.D.