ClearCare
Periodontal & Implant Centre

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CONSENT FOR EXPOSURE AND BRACKETING OF IMPACTED TOOTH

Patient's Name:_____Date:_____

My doctor has explained that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance such risks include, but are not limited to, the following:

- Postoperative discomfort and swelling that may require several days of at-home recuperation. Prolonged bleeding that may require additional treatment.
- Injury or damage to adjacent teeth or fillings requiring restoration or extraction of involved teeth.
- Postoperative infection that may require additional treatment.
- Stretching of the corners of the mouth that may cause cracking and bruising.
- Restricted mouth opening that is related to swelling, muscle soreness or stress on the jaw joints (TMJ), especially when TMJ problems already exist.
- Injury to nerves resulting in numbness or tingling of the chin, lip, cheek, gums, palate, and/or tongue which may persist for several weeks, months or, in rare instances, permanently.
- Opening into the maxillary sinus (a normal cavity situated above the upper teeth) or nasal cavity requiring additional surgery or treatment.
- Allergic reactions to any of the medications used in the procedure.
- I understand that if brackets are placed, sometimes they may come off. In which case additional surgery or procedure may be required to replace them.

While performing my dental surgery I recognize that my Doctor may discover other or different conditions than expected. This may require different or additional procedures than those planned or may require termination of my surgery. I authorize my doctor to perform such other procedures as they deem medically and/or surgically necessary in their professional judgment or to stop my procedure. I understand that no warranties or guarantees of any kind have been made to me or anyone about the results of my surgery or procedure(s). I have been given adequate opportunity to read this entire form and to ask any questions about my surgery or procedure(s) before signing this form. I have been informed of the reason for my surgery, the risks involved, and possible alternate methods of treatment, if any, and I elect to undergo the treatment my doctor has proposed. I certify that I have read and fully understand the terms and words in the above consent and /or any verbal explanations given to

me by my doctor and/or the assistants, and that I give my consent voluntarily. I also certify that if I am not the patient that I am the legal guardian and/or power of attorney for the patient for whom I am completing this form.

Patient's Signature: _____Date: _____

Parent/Legal Guardian's Name: _____Relationship: _____

Parent/Legal Guardian/POA Signature: _____Date: _____

Witness's Name: _____

Witness Signature: _____Date _____