****

**ORAL SURGERY CONSENT**

I hereby authorize Dr. Robert Hubbard to perform simple and surgical oral extractions. The doctor has explained to me the proposed treatment and the anticipated results. I understand this is an elective procedure and that there are other forms of treatment available- including the option of no treatment.

The doctor has explained to me that there are certain risks in this treatment plan or procedure. These include, but are not limited to:

* Injury to a nerve resulting in numbness or tingling of the lip, chin, cheek, gums, and/or tongue on the operated side, This may persist for several weeks, months, or in remote instances- permanently.
* Postoperative infection requiring additional treatment.
* Opening of the sinus requiring different surgery.
* Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint.
* Injury to adjacent teeth and fillings.
* In rare circumstances- cardiac arrest or breakage of the jaw.
* Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation.
* Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
* Stretching of the corners of the mouth with resultant cracking and bruising.

Unforeseen conditions may arise during the procedure that requires a different procedure than set forth above. I therefore authorize the doctor to perform such procedures when they are deemed necessary due to professional judgment. I also understand that the medications, drugs, anesthetics, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I understand that I should not consume alcohol or other drugs because they can increase these effects or cause other harm. I have been advised not to work and not to operate a vehicle, automobile, or any other hazardous devices while taking such medications until full recovered from the effects.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

**PLEASE DO NOT HESITATE TO ASK THE DOCTOR OR STAFF IF YOU HAVE ANY QUESTIONS.**

**PATIENT NAME: .**

**PATIENT/PARENT/GUARDIAN SIGNATURE: .DATE: .**

Hubbard Dental Care 120 W Bower Harrison, AR 72601 Phone: (870)741-1050 Fax: (870)741-1087