SENIOR smile
Namita K. Thapar-Dua, DDS
Providing Mobile Dental Care
Serving Maryland, DC & Virginia
301.875.7477

# CONSENT TO ORAL SURGERY

## (extractions with topical and local anesthesia)

I hereby authorize, Dr. Thapar-Dua with the assistance of others selected by her, to treat the following conditions:

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The alternatives to treat the condition(s) have been explained to me. I have had the opportunity to discuss these alternatives with Dr. Thapar-Dua to my full satisfaction.

The procedure(s) recommended by Dr. Thapar-Dua to treat my condition(s) have been explained to me and I agree to undergo the following treatment/procedure/surgery:

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In addition to the procedure(s) listed above, I authorize Dr. Thapar-Dua to treat or correct any unexpected condition found or problem occurring during treatment/procedure/surgery.

I understand that there are certain inherent risks in any dental procedure, especially oral surgery. Dr. Thapar-Dua has explained these risks to my full satisfaction. All of my questions regarding the risks of surgery have been answered. My discussion with Dr. Thapar-Dua covered many possible risks including, but not limited to, the risks of infection, bleeding and scarring. Injury to nerves may occur causing numbness and/or loss of function both of which may be permanent. In addition, I understand that the treatment/procedure/surgery may cause damage to the area surrounding the site of the surgery such as breakage of a filling, tooth or jaw, soft tissue injury, a persistent opening of one or more sinuses or injury to the temporomandibular joint (jaw joint).

I consent to the use of local anesthesia as needed for this treatment/procedure/surgery. It is explained that profound numbness will be obtained and necessary for patient comfort during the procedure. I have not taken and will not take any undisclosed medications or drugs prior to treatment/procedure/surgery.

No guarantee or assurance has been given me by anyone that the proposed treatment/procedure/surgery will cure or improve the condition(s) listed above.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND ALL OF THE WORDS AND INFORMATION CONTAINED IN THIS FORM AND THAT ALL BLANKS WERE FILLED IN BEFORE I SIGNED THIS DOCUMENT.

Signature: _____ Date: _____ Time: _____
*Patient, Power of Attorney or Guardian*

Signature: _____ Date: _____ Time: _____
*Witness (if available at the appt)*

Signature: _____ Date: _____ Time: _____
*Dentist*