

**Ted R. McCurdy, DDS  
R. Terry Ellis, DDS  
1718 Memorial Drive  
Clarksville, Tennessee 37043  
(931) 552-4935  
(800)935-3999**

## **CONSENT FOR SURGERY AND ANESTHESIA**

**Dear Patient,**

You have a right to be informed about your diagnosis and planned surgery so that you may make a decision whether to undergo the procedure after knowing possible risks and hazards. This disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so you may give your informed consent to the procedure. Please understand that a normal consequence of successful surgery consists of varying degrees of postoperative discomfort, swelling and bleeding.

### **POSSIBLE COMPLICATIONS OF ORAL SURGERY AND ANESTHESIA**

#### **1. ALL SURGERY:**

- A. Soreness, swelling, bruising, and restrictive mouth opening during healing sometimes related to swelling and, muscle soreness and sometimes related to stress on the jaw joint TMJ especially when TMJ problems already exist.
- B. Bleeding, can usually be easily controlled but may be prolonged and require additional care.
- C. Drug reactions or allergy.
- D. Infection, possibly requiring additional care to include surgery and/or medication.

#### **2. ALL TOOTH EXTRACTIONS,**

- A. Dry socket - discomfort and pain occurring a few days after extraction, requires further care.
- B. Damage to adjacent teeth or fillings.
- C. Sharp ridges or bone splinters may require additional surgery to smooth the area.
- D. Portions of tooth remaining-sometimes fine root tips break off and may be deliberately left in place to avoid damaging nearby vital structures such as nerve blood vessels or the sinus.

#### **3. LOWER TEETH**

**NUMBNESS** - Due to the closeness of the roots to the nerve (especially wisdom teeth), it is possible to injure the nerve during the removal of a tooth. The lip, chin, gums, cheek or tongue could thus feel numb (resembling the effects of local anesthetic) or painful...this could remain for days weeks, months, or very rarely permanently.

#### **4. UPPER TEETH**

**SINUS INVOLVEMENT** - Due to the closeness of the roots of upper back teeth to the sinus or from a root tip or tooth being displaced into the sinus. A sinus infection and/or sinus opening may result which could require medication and/or a separate surgery at a later date.

5. ANESTHESIA

a. LOCAL ANESTHESIA: Possible risks exist that could include pain, swelling, bruising, infection, nerve damage (numbness), and unexpected allergic reactions which could result in heart attack, stroke, brain damage, and/or death.

b. INTRAVENOUS SEDATION OR GENERAL ANESTHESIA: Risks that although uncommon, could include nausea, pain, swelling, inflammation, and/or bruising at the injection site. Risks associated with LOCAL ANESTHESIA are also applicable. Rare complications include nerve, muscle, or blood vessel injury (phlebitis) in the arm or hand, allergic or unexpected drug reactions, pneumonia, stroke, heart attack, brain damage, and/or death.

**I UNDERSTAND THAT IF I AM TO HAVE INTRAVENOUS ANESTHESIA THAT I AM NOT TO HAVE FOOD OR DRINK FOR SIX (6) HOURS PRIOR TO MY APPOINTMENT. TO DO OTHERWISE MAY BE LIFE THREATENING!**

Patients rarely experience any significant problems during or following oral surgery and anesthesia. You are not at an increased risk for complications, unless your physician has specifically advised you of some underlying problem. Although there are no guarantees in surgical practice, you should anticipate an uneventful treatment and healing experience.

Patient name: \_\_\_\_\_

I hereby authorize Dr. McCurdy or Dr. Ellis and their staff as selected by them to perform the following procedure(s):

\_\_\_\_\_ and to administer the anesthesia which I have chosen, which is [ ] local, [ ] IV monitored anesthesia care. I understand that the surgeons may discover other or different conditions that may require additional or different procedures from those planned. I authorize them to perform such other procedures as they deem necessary in their professional judgment in order to complete my surgery. Photos may be taken to document my care as needed.

I have read and discussed the preceding information with Dr. McCurdy or Dr. Ellis and believe I have been given sufficient information to give my consent to the planned surgery. My questions have been answered in a satisfying way.

By your signature you give up no rights and do not release the surgeon from any responsibility. You have the right to decline any recommended surgical care at any time.

\_\_\_\_\_  
Patient or Legal Guardian Signature Date & Time

\_\_\_\_\_  
Witness & Date

\_\_\_\_\_  
Dr. McCurdy/Dr. Ellis