NORTHEAST
Dental Group

Northeast Dental Group

'A Dental Destination Location'

7770 Frontage Rd #7341 Cicero, NY 13039

CONSENT FOR ENUCLEATION OF ANTERIOR MAXILLARY CYST (APEX OF #8,9) VIA PERCUTANEOUS AND/OR INTRAORAL APPROACH

Patient's Name Date

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING

You have the right to be given information about your proposed surgery so that you may make an informed decision to have or not have surgery.

In your case, the area of concern is:

It is planned to:

- ❑ Take out all the suspected tissue. If the biopsy report is suspicious for disease, we may need to take out more tissues to get a margin of safety,

OR

- ❑ Remove only enough tissue to get a good sample, leaving the rest behind. (This is usually done when the lesion is large, there is no cancer suspected, or the removal of all of it at this time would be unnecessarily difficult.) However, if the biopsy report is suspicious for disease, the entire lesion may have to be removed later.

Alternative treatment: methods include: no treatment/partial treatment/defer treatment

Discussed in detail risks, benefits, and procedure of enucleation and curettage versus marginal resection. Patient elects for enucleation and curettage.

_____1. I understand the treatment option I am selecting (enucleation and curettage) has a higher chance of recurrence and will likely need repeat treatment in the future

_____2. I understand that a biopsy requires a cut(s) in my mouth or on the skin that will need stitches, and sometimes the removal of bone tissue. My doctor has told me that there are certain risks that can occur with the surgery, including (but not limited to):

____ A. Post-operative pain and swelling that may require several days of at-home recuperation.
____ B. Bleeding that is heavy or may last a long time that may need additional treatment.
____ C. An infection after the procedure that may need more treatment.
____ D. Stretching of the corners of the mouth that may cause cracking and bruising and which may heal slowly.
____ E. A difficulty in opening the mouth for several days. This is sometimes due to swelling and muscle soreness and sometimes to stress on the jaw joints (TMJ).
____ F. Reactions to medications, anesthetics, sutures, etc.
____ G. Injury to the nerves in the area of the biopsy which may result in pain or a tingling or numb feeling in the lip, chin, tongue (including the possibility of loss of taste sensation), cheek, gums or teeth, or in areas of the skin of the face. Usually this disappears slowly over several weeks or months, but sometimes the effects may be permanent.
____ H. If bone tissue is removed, healing may take longer, some complications may be more likely (for example, bleeding), and the biopsy report may take longer due to special processing requirements.
____ I. Opening into the sinus (a normal hollow place above the upper back teeth) needing more treatment.
____ J. There is always a possibility that the lesion might come back in the same area, even when it appears to be totally removed.
____ K. Abnormal, enlarged, or cosmetically unpleasing scars may occur within the skin and deeper tissue, sometimes requiring additional surgery. Some scarring may be permanent and always be visible.
____ L. Loss of function and/or weakness of facial expression muscles possibly affecting my appearance. Such conditions may resolve over time, but in some cases may be permanent.
____ M. Changes in speech, chewing, and swallowing. Such conditions may resolve over time, but in some cases may be permanent.
____ N. Malocclusion. My teeth may not “fit” in the same manner as prior to the surgery
____ O. Need for additional surgery due to recurrence

_____3. It is likely that your procedure will include local anesthesia. Local anesthesia is a shot given to block pain in the area to be worked on.

_____4. I understand that I may need to come back to see the doctor for follow-up for a long time, even if the biopsy report shows no cancer. I understand that if I need to and don’t return for follow-up, my condition may get to a point where I might need more care or more surgery, or the lesion might come back and be a threat to my health. I agree to schedule exams as instructed by the doctor and to tell the doctor if I think there is a change in my condition.

_____5. It is understood all encounters at Northeast Dental Group, including my consultation/surgery/follow-up/phone calls may be recorded for the purpose of training and/or documentation. This recording may become part of my permanent dental record or may be discarded at the sole discretion of the dental office.

CONSENT

I understand that my doctor can't promise that everything will be perfect. I have read and understand the above and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature	Date
Doctor's Signature	Date
Witness' Signature	Date