NORTHEAST
Dental Group

Northeast Dental Group

'A Dental Destination Location'

7770 Frontage Rd #7341
Cicero, NY 13039

Consent for Incision and Drainage

You have the right to be informed about your condition and the recommended treatment plan. This disclosure is meant to provide information to help you understand the possible risks and complications of treatment, so you may decide to give or withhold your consent.

Patient's Name **Today's Date**

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

My condition has been explained to me as an **abscess** – an advanced infection that has caused a localized collection of infected fluids. The primary treatment of an abscess is to drain the area – called "Incision and Drainage" – to assist healing and to allow other treatment such as antibiotics, etc. to work better.

____ 1. The procedure(s) necessary to treat my condition(s) has/have been explained to me and I understand the nature of the treatment to be:
incision and drainage of tooth # with Local anesthesia

____ 2. I have been informed of possible alternate methods of treatment (if any) including:
No treatment/partial treatment/ defer treatment

I understand that these other forms of treatment, or no treatment at all, are choices I have and the risks of those choices have been presented to me.

____ 3. My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment and, in this specific instance, they include, but are not limited to:

____A. Post-operative discomfort and swelling that may require several days of at-home recovery.

____B. Infections are often difficult to cure and may require additional (sometimes complex and prolonged) treatment even after the incision and drainage procedure.

____C. Prolonged or heavy bleeding that may require additional treatment.

____D. Injury or damage to structures or tissues (blood vessels, nerves, salivary glands or ducts, bone, etc.) that lie deep to the skin or gum/cheek mucosa and cannot be readily identified.

____E. Injury to sensory nerves in the area (undetectable by any exact means) that may result in pain, numbness, tingling or other sensory disturbances in the chin, lip,

cheek, teeth, gums or tongue (including possible loss of taste sensation), and which may persist for several weeks or months, or in rare cases, may be permanent.

____F. More rarely, motor nerves in the area of the incision may be affected, which may result in diminished function of muscles of facial expression.

____G. Placement of drains (rubber or fabric) that are often sutured to place and require removal. after several days. Such drains may add to discomfort and interfere with normal function.

____H. Stretching of the corners of the mouth that may cause cracking or bruising, and may heal slowly.

____I. Allergic reactions (previously unknown) to any medications used in treatment.

____J. Restricted mouth opening during healing, sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.

____K. If the approach to the abscess necessitates a skin incision, there will be some evidence of scarring that will be permanent. Such scarring may sometimes be repaired by additional plastic surgery.

____ 4. During the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph 2 above. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

____ 5. The anesthetic I have chosen for my surgery is: □ Local Anesthesia □ Local anesthesia with Nitrous/Oxide/Oxygen Analgesia □ Local Anesthesia with Oral Premedication □ Local Anesthesia with Intravenous Sedation □ General anesthesia

____ 6. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation (phlebitis) at the site of an intravenous injection that may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and although considered safe, does carry the rare risks of heart irregularities, heart attack, stroke, brain damage or other very serious medical consequences.

____7. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED:**

A. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours. **Unless a qualified driver is present before surgery, the appointment will be canceled!**
B. During recovery time you should not drive, operate complicated machinery or devices, or make important business decisions.
C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE **NOTHING** TO EAT OR DRINK **FOR 6 HOURS** PRIOR TO YOUR ANESTHETIC. **TO DO OTHERWISE MAY BE LIFE-THREATENING!**
D. **However**, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using only a small sip of water.**
E.

____ 8. It has been explained to me, and I fully understand, that a perfect result is not or cannot be guaranteed. I understand that the infection could worsen, necessitating hospitalization for continued treatment and/or further surgical procedures to eliminate this infection.

____ 9. It is understood all encounters at Exclusive Oral Surgery LLC, 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.

I have read and fully understand this consent for surgery, and have had all questions answered prior to my initials or signature.
PLEASE ASK YOUR DOCTOR IF YOU HAVE ANY QUESTIONS ABOUT THIS CONSENT FORM.

Patient or Legal Guardian's Signature Date

Doctor's Signature Date

Witness' Signature Date