INCREDIBLE Smiles™

Oral Surgery Consent Form

I hereby authorize Priya Uppal, DDS and to perform the following procedures:

_____

The doctor and/or staff have explained to me the proposed treatment and the anticipated results of such treatment. I understand, acknowledge, and expressly accept this is an elective procedure and there are other forms of treatment available, including the option of no treatment. The doctor has explained to me there are certain potential risks in the treatment plan or procedure. I authorize this treatment plan and acknowledge and willingly accept and fully understand all the risks. The risks include, but are not limited to:

_____ Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums, and/or tongue to the operated side. This may persist for several weeks, months, or in remote instances, permanently.
_____ Postoperative infection requiring additional treatment.
_____ Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
_____ Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint.
_____ Injury or fractures to adjacent teeth, fillings and/or crowns. If such damage occurs the fees for replacing or restoring damage is the guest's responsibility.
_____ 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 requires extensive surgery.
_____ Stretching of the corners of the mouth with resultant cracking and bruising.

I also understand, acknowledge, and accept that unforeseen conditions may arise during the procedure that requires a different procedure than as set forth above. I therefore expressly authorize the doctor and any associates to perform such procedures when, in their professional judgment, are medically necessary. I understand, acknowledge, and accept that the medications, drugs, anesthetic, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand, acknowledge, and accept that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects. **I have also been advised not to smoke for two weeks after the surgery.**

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

By signature to this document, I state that I understand the nature and risks of the treatment plan and expressly authorize the treatment. I expressly authorize and state that all the terms of this document are understood by me and that I consent to the treatment plan, including any changes to the treatment plan made by the doctor during the course of the treatment.

_____ _____
Signature of guest or guardian Date

_____
Print name

_____ _____
Signature of doctor Date

www.IncredibleSmiles.com
4150 Darley Avenue, Suite 3 Boulder, CO 80305 phone: 303.499.0013 fax: 303.499.0023