



SAN ANTONIO

PERIODONTICS & IMPLANTS

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CAVITATION SURGERY PATIENT INFORMATION AND CONSENT FORM

I have been informed and I understand the purpose and nature of the cavitation surgical procedure. I understand what is necessary to accomplish this procedure.

My doctor has carefully examined my mouth. Alternatives to this treatment have been explained, including no treatment. I have considered these methods and I decided to have the root amputated from this tooth as it has been explained to me.

With this consent form, I am being informed of the possible risks and complications involved with surgery, drugs and anesthesia. Such complications include, but are not limited to, numbness of the lip, tongue, chin, cheek, gums or teeth, pain, swelling, infections, bleeding, and discolorations. The exact duration may not be determinable and may be irreversible. Also possible are injury to teeth or adjacent structures, bone fractures, sinus perforation, delayed healing, adverse reaction or allergy to drugs or medications used, etc., as well as TMJ (jaw joint) problems such as headaches, referred pain to the back of the neck, facial muscles and tired muscles from chewing.

My doctor has explained that there is no method to accurately predict the gum and bone healing capabilities in each patient following surgical procedures. In some instances, cavitations recur and may need to be redone. I have been informed and I understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of results of treatment or surgery can be made.

I understand that excessive alcohol, sugar intake, smoking and poor oral hygiene may limit the success of the procedure. I agree to follow my doctor's home care instructions and to report to him for regular examinations as instructed.

To my knowledge, I have given an accurate report of my physical and mental history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition related to my health including a history of taking medications that may alter bone physiology (bisphosphonates such as Fosamax, Boniva, Actonel, Zometa etc.).

I request and authorize medical/dental and surgical services for me. I fully understand that during and following the contemplated procedure(s), surgery or treatment, conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of the comprehensive treatment. I also approve any modification in design, material or care, if it is felt this is in my best interest.

Patient's (or Legal Guardian's) Signature

Date

Witness

Date

Patient's Name

Tooth Number/Area

