STARCK
ORAL SURGERY

WILLIAM J. STARCK, DDS
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DISCLOSURE & CONSENT FOR ORAL & MAXILLOFACIAL SURGERY

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and about the recommended surgical, medical, or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you can give or withhold your consent to the procedure.*

I voluntarily request William J. Starck, DDS and such associates, technical assistants, and other healthcare providers as he may deem necessary, to treat my condition which has been explained to me(us) as_____

_____

The procedure(s) necessary to treat the condition(s) has/have been explained to me(us), and I(we) understand the nature of the treatment to be_____

_____

Alternative method(s) of treatment_____

I(we) have chosen the following anesthetic for my surgery: ☐ Local anesthesia ☐ Local anesthesia w/ nitrous oxide/oxygen analgesia ☐ Local anesthesia w/ oral premedication ☐ Local anesthesia w/ intravenous (IV) sedation ☐ General anesthesia w/ local anesthesia

I(we) understand that Dr. Starck may discover other or different conditions which require additional or different procedures than those planned. I(we) authorize Dr. Starck and such associates, technical assistants, and other healthcare providers to perform such other procedures which are advisable in their professional judgment.

I(we) understand that no warranty or guarantee has been made to me as to result or cure. I(we) have been given both oral and written pre- and post-operative instructions, and I(we) agree to personally contact Dr. Starck in the event I(we) have a problem. I(we) will follow his instructions until that problem has been satisfactorily resolved. I(we) realize that in the event I(we) develop certain complications, I(we) may miss school or work schedules or I(we) may incur additional, unexpected expenses, including, but not limited to, expenses for other dentists, doctors, or medical facilities.

I(we) understand that Dr. Starck is not employed by my dentist but that he is an independent contractor and will receive a portion of the fee paid to my dentist for these services. I(we) have chosen Dr. Starck from the alternatives I(we) have been offered to perform my dental surgery. I(we) understand that Dr. Starck is a specialist in oral and maxillofacial surgery.

I(we) understand that just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, intravenous (IV) anesthesia, and/or diagnostic procedures planned for me and that common to those procedures is the potential for: nausea or vomiting; infection; pain; swelling; bleeding; bruising; allergic and/or drug reactions; injury to vocal chords or eyes; respiratory problems; heart irregularities, heart attack, and stroke; paralysis; brain damage; and, even death. I(we) also realize that the risks and hazards that may occur in connection with this particular procedure include the following **(PLEASE INITIAL EACH ITEM BELOW AFTER READING):**

_____A. Temporary or permanent nerve injury resulting in altered sensations or prolonged numbness of the lips, cheeks, chin, tongue, teeth, gums, floor of mouth, and/or face, which may persist for several weeks or months, or which may, in rare instances, be permanent
_____B. Injury or damage to adjacent teeth, dental restorations, or adjacent structures
_____C. Soreness or inflammation at injection sites (phlebitis) and/or along veins, as well as discoloration of the injection sites, face, and/or jaws
_____D. Stretching of the corners of the mouth that may cause cracking, bruising, or slow healing
_____E. Jaw joint (TMJ) tenderness, soreness, pain, or locking, which may be temporary or permanent
_____F. Small root fragment(s) left in the jaw when removal of such would require extensive surgery or risk other complications
_____G. Jaw fracture, muscle spasms, and/or limited opening of jaws for several days or weeks
_____H. Opening of the sinus (a normal chamber situated above the upper teeth), requiring additional surgery or treatment
_____I. Dry socket (loss of blood clot from extraction site)
_____J. Other_____

I(we) have been given an opportunity to ask questions about: a) my condition; b) alternative forms of anesthesia and treatment; c) risks of non-treatment; d) the procedures to be used; and, e) the risks and hazards involved, and I(we) believe that I(we) have sufficient information to give this consent.

I(we) certify that: a) this form has been fully explained to me(us) and that its contents are understood; b) I(we) have read it or have had it read to me(us); c) the blank spaces were filled-in prior to initialing/signing; d) I(we) speak, read, and write English; and, e) I(we) have had my questions answered.

_____	_____
Signature of Patient or Other Legally-responsible Person	/ Patient's Name (Please Print)
_____	_____
Signature of Witness	/ Witness' Name (Please Print)

DATED_____ TIME_____