Chase M.
BAKER, DDS

INFORMED CONSENT FOR PERIODONTAL AND ORAL SURGERY

PATIENT NAME _____ DATE _____

TO THE PATIENT

You have the right, as a patient, to be informed about your condition and the recommended treatment to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks involved. Please ask about anything that you do not understand.

X_____ It has been explained to me by Dr. Chase M. Baker and I understand that I have periodontal disease, which requires the following procedure(s) for successful maintenance:

□Gingivectomy □ Flap Surgery □ Osseous Surgery
□ Bone Graft □ Connective Tissue □Crown Lengthening

X_____ It has been explained to me by Dr. Chase M. Baker and I understand that I have the following conditions, which require treatment:

□Non-treatable bone loss □ Non-treatable extensive decay □ Non-restorable tooth fracture
□ Excessive soft tissue/bone □ Other _____

X_____ That there are alternative treatments for the above condition has been explained and I have chosen the following surgical, medical and/or diagnostic procedures and authorize them to be performed:

□ Extraction of tooth (teeth) # _____ □ Removal of soft tissues/bone
□ Biopsy of:
□ Tooth #_____ □Soft tissue _____ □ Bone tissue from _____
□ Frenectomy _____ □ Other _____

X_____ I understand that the purpose of the procedure/ surgery is to treat and possibly correct my diseased oral tissues. Dr. Baker has advised me that if this condition persists without, treatment or surgery, my present oral condition will probably worsen in time, and the risks to my health may include, but are not limited to, the following: swelling; pain; infection; cyst formation; periodontal (gum) disease; dental caries; malocclusion; pathologic fracture of the jaw; premature loss of teeth; and/or premature loss of bone.

X_____ I am aware that my medical /dental history is very important. I understand that Dr. Chase M. Baker must know the medications and drugs that I have received or am currently taking. Certain types of medications may increase the risk of complications following periodontal or oral surgery. I have had the opportunity to review my medical / dental history with Dr. Chase M. Baker. I have taken or am currently taking:

□Oral Bisphosphonates (Actonel (risedronate), Boniva (clodronate), Didronel (etdronate), Fosamax (alendronate), Skelid (tiludronate)

□ IV Bisphosphonates (Aredia (pamidronate), Bonefos (clodronate), Zometa (zolendronate, zolendronic acid)
□ Anticoagulants/ Platelet Inhibitors (aspirin, Coumadin (warfarin), Plavix (clopidogrel - bisulfate), Heparin, Fragmin (dalteparin)

COMMON RISK

Dr. Baker has explained that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to:

1. Postoperative discomfort and swelling, which may necessitate several days of home recuperation. After extractions, a dry socket may form if the blood clot is disrupted necessitating the need for treatment with medicated dressings for up to 10 (ten) days
2. Bleeding that may be prolonged.
3. Injury to adjacent teeth.
4. Post-operative infection requiring additional treatment.
5. Stretching of the corners of the mouth with resultant cracking and bruising.
6. Restricted mouth opening for several days or weeks from muscle spasm or swelling.
7. Decisions to leave a small piece of root in the jaw when its removal would require extensive surgery.
8. Breakage of the jaw (primarily during lower molar extractions).
9. Injury to the nerve underlying the lower teeth resulting in numbness or tingling of the lip, chin, gums, cheeks, teeth, and / or tongue on the operated side; this may persist for several weeks, months, or in remote instances permanently.
10. Opening of the sinus (a normal cavity situated closely above the upper back teeth) requiring additional surgery.
11. Injury to bone surrounding teeth being extracted. Rarely, the teeth are even fused to the bone, which may necessitate extra surgical procedures to remove the teeth.

PLEASE INITIAL EACH OF THE FOLLOWING:

X_____ I AGREE AND UNDERSTAND I AM NOT TO HAVE AND /OR HAVE NOT HAD ANYTHING TO EAT OR DRINK FOR _____HOURS BEFORE MY SURGERY.

X_____ I CONSENT TO THE USE OF SUCH LOCAL ANESTHESIA AS DEEMED NECESSARY BY DR. BAKER TO ACCOMPLISH THE PROPOSED PROCEDURE.

X_____ I HAVE BEEN GIVEN CONSENT FOR FOR ANY OTHER KIND OF SEDATION/ ANESTHESIA.

X_____IF ANY UNFORSEEN CONDITION SHOULD ARISE IN THE COURSE OF THE OPERATION, CALLING FOR DR. BAKER'S JUDGMENT OF OTHER PROCEDURES IN ADDITIION TO OR DIFFERENT FROM THOSE NOW CONTEMPLATED, I REQUEST AND AUTHORIZE DR. BAKER TO DO AS HE MAY DEEM NECESSARY.

X_____ I HAVE HAD AN OPPORTUNITY TO DISCUSS WITH DR. BAKER MY PAST MEDICAL HISTORY INCLUDING ANY SERIOUS PROBLEMS AND INJURIES.

X_____ I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF DR. BAKER WHILE I AM UNDER HIS CARE, REALIZING THAT ANY LACK OF THE SAME COULD RESULT IN A LESS THAN OPTIMUM RESULT.

X_____DUE TO INDIVIDUAL PATIENT DIFFERENCES THERE EXISTS A RISK OF FAILURE, RELAPSE, NEED FOR SELECTIVE RE-TREATMENT, OR WORSENING OF MY PRESENT CONDITION DESPITE THE CARE PROVIDED. HOWEVER, IT IS IN DR. BAKER'S OPINION THAT THERAPY WOULD BE HELPFUL, AND THAT WORSENING OF MY CONDITION WOULD OCCUR SOONER WITHOUT THE RECOMMENDED TREATMENT.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ FULLY AND UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO THE PROCEDURE AND THE EXPLANATION REFERRED TO OR MADE, ALL BLANKS AND OR STATEMENTS REQUIRING

INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE THAT I READ AND WRITE ENGLISH.

- o I GIVE CONSENT FOR THE TREATMENT AS DESCRIBED ABOVE.
- o I REFUSE TO GIVE MY CONSENT FOR THE PROPOSED TREATMENT AS DESCRIBED ABOVE. I HAVE BEEN EXPLAINED AND UNDERSTAND THE POTENTIAL CONSEQUENECES OF MY CHOICE.

X_____ X_____

PATIENT, PARENT, GUARDIAN CHASE M. BAKER, D.D.S.

X_____ X_____

WITNESS DATE