B225-3122 Mount Lehman Rd
Abbotsford, B.C. V2T-0C5 (604)381-3399

Oral Surgery Consent Form

Patient:_____ Date:_____

I, _____ consent to the preforming of the prescribed surgery procedure(s) including the use of local anesthetic (dental freezing) as indicated. I have been informed of the potential risks of such procedure(s) including but not limited to:

1. Temporary or permanent numbness of the lip and/or tongue
2. Dry socket
3. Bleeding
4. Bruising
5. Swelling
6. Oral antral communication (opening between tooth socket and sinus)
7. Infection

The prescribed treatment of _____ has been explained to me along with the alternative(s), including not having any treatment done. I understand the benefits and importance of such treatment and will assume the responsibility for the fees associated with these procedures.

X _____ X _____

Patient/Guardian Witness