Palladium Dental

Consent for oral surgery / wisdom teeth removal

Patient name: _____

I have been advised to have the following procedure (s) performed:

_____

_____

I understand why this treatment has been recommended. I understand the nature of the surgical procedure and have had the opportunity to discuss it with my dentist.
All the available treatment options were presented to me. I have made an informed decision to consent to the procedure.
I understand that wisdom teeth removal, like any surgical procedure, is not without risk. These risks include:

○Swelling and stiffness of the jaw.
○Bleeding
○Pain and discomfort
○Infection
○Dry socket
○Damage to adjacent teeth and fractures of the mandible.
○Numbness, tingling and altered sensation of the lip, chin, tongue, gums and teeth possibly due to the proximity of nerves which supply these areas.
○Sinus perforation, communication or root displacement.
○Allergy or other adverse reaction to drugs which administered.

The risks and benefits for the procedure have been discussed with me to my satisfaction, including the risks and benefits of no treatment.

_____ _____

Patient name (please print) Date

_____

Patient / Guardian Signature