Oral and Maxillofacial Surgery Associates of
Chester County, LTD.

Consent For Surgery

Date_____ Patient Name Acct.#

_____This is my consent to authorize Drs. Disque, Gustainis and Trentacosti to perform the following procedures:

_____

_____

as previously explained to me, or other procedure deemed necessary or advisable to complete the planned operation.

_____I understand that the purpose of my surgery is to treat skeletal (bony) and/or soft tissue deformities (malpositioned upper and/or lower jaw and/or chin). My doctor has advised me that without the surgery early tooth loss, temporomandibular joint derangement (jaw joint pain and/or degeneration) or relapse of my orthodontic treatment could occur. I also understand that if difficulty with speech, mastication (chewing) and pain in the jaw joint area is present, that surgery may not alleviate the problems.

_____Alternative treatment methods have been discussed with me. They include:

1. No surgery
2. Orthodontic tooth movement only
3. _____

_____I understand that complications could arise during and/or after surgery and give permission to my doctor to treat those complications as he/she deems necessary. He/She has discussed the potential risks associated with my treatment plan, included but are not limited to:

1. Bleeding during surgery that may be prolonged or require transfusion.
2. Bruising of my face.
3. Postoperative discomfort, pain and swelling of my face.
4. Numbness, tingling, and/or pain of my lips, tongue, chin, gums, cheeks, teeth, palate (roof of mouth) which may be temporary or permanent.
5. Stretching of the corners of the mouth with temporary soreness and cracking.
6. Allergic reaction to medicines.
7. Pain, numbness, and/or bumps (phlebitis-inflammation of the vein) from intravenous injections and/or intramuscular injections.
8. Stiffening of the jaw and/or facial muscles.
9. Injury to adjacent teeth and/or fillings in teeth with possible need for root canal treatment. Loss of a tooth or teeth along with a portion of bone is also possible.

10. Development of postoperative sinus infection or opening.
11. Unfavorable bone fractures.
12. Delayed healing or non-healing of the bony segments.
13. Temporomandibular (jaw) joint noise, pain, or stiffness.
14. Changes in the appearance of my face and nose.
15. Need for additional surgical procedures.
16. Relapse of the jaw towards the original position.
17. Failure to achieve desired result.
18. Scarring of soft tissues inside and outside of mouth.
19. Infection which could require antibiotics and additional surgery.
20. I understand that this surgical procedure(s) may necessitate the wiring of my teeth together for several weeks and I agree to comply with this.

_____I understand that general anesthesia has risks which could involve serious bodily injury or even death. I have been instructed to not have anything to eat or drink for eight (8) hours before surgery.

_____I have discussed in full my past and current medical illness and medications and I have not withheld any information regarding these items.

_____I agree to cooperate completely with the recommendations of my doctor while under his/her care, realizing that failure to do so could result in a less than optimum result.

_____I understand that there is no warranty or guarantee as to the result of the proposed surgery, and that my condition, might return, or become worse.

_____The fee for my surgery has been explained to me and is satisfactory. I understand that I am responsible for that portion of the fee which my insurance does not pay.

_____I have been provided with a copy of the patient information pamphlet and have read it.

_____I certify that I have had the opportunity to read, discuss and fully understand the terms and words in this consent to the proposed operation and have had the opportunity to ask questions. I also understand that I may contact my doctor should I have additional questions. All blanks were filled in before I signed. I have initialed all paragraphs which were applicable and those which were crossed out.

Patient, Parent or Guardian_____Date_____

Witness_____ Date_____

Dr._____ Date_____