REYNOLDS
ORAL & FACIAL
SURGERY

CONSENT FOR PLACEMENT OF EXPANDER

Patient's Name:_____ **Date**_____

PLEASE CHECK EACH BOX AFTER READING. If you have any questions please ask your doctor.

You have the right to be given pertinent information about your proposed surgery so that you may make an informed decision as to whether or not to proceed.

- ❑ I authorize Dr. Reynolds/Dr. Auble to perform the following procedure:_____
  _____
- ❑ I understand that a placing the expander requires an incision(s) in the skin that will require stitches. I understand that there are certain risks associated with the surgery, including (but not limited to):
  - ❑ Post-operative discomfort and swelling that may require several days of at-home recuperation.
  - ❑ Prolonged or heavy bleeding that may require additional treatment.
  - ❑ Post-operative infection that may require additional treatment.
  - ❑ Reactions to medications, anesthetics, sutures, etc.
  - ❑ Injury to sensory nerve branches in the area of the expander which may result in pain or a tingling or numb feeling or in areas of the skin of the scalp. Usually this disappears slowly over several weeks or months, but occasionally the effects may be permanent.
  - ❑ Loss of hair in the area of the incision or expander tissue.
  - ❑ Other:_____
- ❑ I understand that I may be given appointments for long-term follow-up care. I recognize the importance of returning for such follow-up that, if not done, may allow progression of my condition to a state requiring additional care or further surgery, or the lesion may recur and become a threat to my health. I agree to comply by regularly scheduling exams as instructed and to notify this office if I suspect a change in my condition.

ADDITIONAL AGREEMENTS AND AUTHORIZATIONS

- ❑ I understand smoking is extremely detrimental to the healing process. **I agree to cease all use of tobacco for 6 weeks prior to and 6 months after surgery and to make strong efforts to give up smoking entirely.**
- ❑ Recognizing that during the surgery some unforeseen condition may be discovered that may necessitate a change in approach or different procedure from those explained above, I authorize Dr. Reynolds/Dr. Auble to perform such procedures as are necessary and advisable in the exercise of his professional judgment.
- ❑ No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that the treatment would be helpful, and I have weighed the risk with the proposed benefits.
- ❑ I have discussed my past medical history with the doctor and have disclosed **ALL** diseases and medications, including alcohol and drug use past and present.
- ❑ I agree to cooperate completely with the recommendations of Dr. Reynolds/Dr. Auble, realizing that lack of cooperation may result in a less than optimal result.
- ❑ I have reviewed / viewed pre-operative and post-operative instructions.
- ❑ I understand that oral hygiene will be difficult following surgery, but will do my utmost to follow normal tooth brushing and oral hygiene routines.

REYNOLDS
ORAL & FACIAL
SURGERY

I certify that I have had an opportunity to read and fully understand the terms within the above consent and the explanation made, and that all blanks or statements requiring completion were filled in, and any inapplicable paragraphs were stricken before I signed. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the procedure.

Patient's (or Legal Guardian's) Signature	Date
Doctor's Signature	Date
Witness' Signature	Date