REYNOLDS
ORAL & FACIAL
SURGERY

CONSENT FOR EXPOSURE, UNCOVERING AND/OR BRACKETING OF UNERUPTED TEETH

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

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

- ❑ I authorize Dr. Reynolds/Dr. Auble to perform the following procedure(s):_____
- ❑ These procedures are necessary to treat the following condition(s):_____
- ❑ The possible alternate methods of treatment (if any), include:_____
- ❑ I understand that certain risks and complications are associated with my surgery, which include (but are not limited to):
  - ❑ Swelling, soreness, bruising, stiffness of jaw muscles and jaw joints (TMJ), unexpected drug reactions or allergies, and fracture of the jaw or portions of bone supporting teeth, and difficulty eating for a number of days.
  - ❑ Post-operative infection that may require additional treatment.
  - ❑ Because of the exposure required to gain access to certain teeth buried in the jaw bone, beneath the gum, areas around the exposure may feel numb for days, weeks or months after surgery. In rare cases this feeling may be permanent.
  - ❑ Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums or tongue (including possible loss of taste sensation) which may persist for several weeks, months or, in rare instances, be permanent.
  - ❑ Certain teeth to be uncovered often are very close to roots of adjacent teeth. There is a chance that those roots may be injured, requiring later root canal treatment or, in rare instances, may result in the loss of those teeth.
  - ❑ Although usually only one incision is needed to approach the buried tooth, sometimes the position of the unerupted tooth is complicated enough to require two or more incisions.
  - ❑ When approaching upper back teeth, there is a chance that the sinus may be entered, possibly requiring antibiotic and/or decongestant therapy, or possibly resulting in an opening between mouth and sinus that may require further care. Rarely, the same complication may affect the nasal cavity.
  - ❑ Often an orthodontic bracket and/or a wire or fine chain is attached to the unerupted tooth; then to orthodontic appliances to gain the force to try to move the unerupted tooth. This may cause irritation to your tongue and interfere somewhat with eating or speech. You will usually adjust to this situation fairly quickly.
  - ❑ Occasionally the applied bracket will become detached and must be re-attached which may require another surgery.
  - ❑ Although it cannot be determined beforehand, sometimes the desired movement of the uncovered tooth does not occur or cannot be accomplished. If so, the tooth may be left in place or a surgery may be necessary to move the tooth with the bone, or if necessary, the unerupted tooth may need to be removed.
  - ❑ As the tooth moves into position it may be necessary to have another surgery to ensure the tooth is surrounded by attached gingival (gums).

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.

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- ❑ 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.

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