CONSENT to TREATMENT, SURGERY and ANESTHESIA

			A	B	C	D	E	F	G	H	I	J			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
			T	S	R	Q	P	O	N	M	L	K			

I hereby authorize doctors Zarrinkelk and Associates with the assistance of others selected by them to treat the following condition(s):_____

_____

The procedure(s) recommended by doctors Zarrinkelk & Associates have been explained to me, and I agree to undergo the following treatment / surgery:_____

_____

I have had the opportunity to discuss the alternatives listed below with my doctor to my full satisfaction:_____

_____

In addition to the procedures listed above, I authorize doctor Zarrinkelk to treat or correct any unexpected condition found or complications that may occur during the procedure. I understand that there are certain inherent risks in any Oral and Maxillofacial surgery or treatment. Doctor Zarrinkelk has explained these risks to my full satisfaction. All of my questions regarding the risks of the treatment or surgery have been answered. No guarantee or assurance has been given or implied to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above. My discussion with doctor Zarrinkelk has covered many possible risks **including but not limited** to the following:

- Swelling that worsens after 48 hours, prolonged bleeding, Infection, Pain and Discomfort;
- Permanent loss or alteration of nerve sensation resulting in numbness or tingling sensation in the lip, tongue, cheek, chin, gums, teeth and face;
- Sinus infection, sinus perforation or complications;
- Temporomandibular joint pain or abnormal function of the jaw;
- Damage to teeth, roots, bone or soft tissue structures; Jaw fracture;
- Fracture or damage to dental restorations, fillings, crowns, etc.
- Bone loss around the adjacent teeth;
- Loss of grafted material including artificial or autogenous bone and soft tissue.

In addition to being advised of the risk, benefits and alternatives of the proposed treatment plan, I (or patients guardian) have been offered the option of having general anesthesia or conscious sedation anesthesia administered by doctor Zarrinkelk. I (We) have also been advised of the following: General anesthesia or sedation is accomplished by the administration of medication, generally by injection, which sedates and relaxes a patient during treatment. As with administration of any medication, there are potential risks and side effects that may be experienced by the patient. The medications used, can in rare cases, cause an allergic reaction that can manifest by symptoms such as: hives, rashes, nausea, sweating and vomiting. In very rare and unpredictable cases the reactions to anesthesia medications have been life threatening. I (We) have been informed that complications during anesthesia can cause serious permanent injuries and death. At the end of treatment, there will be a period of "recovery" during which I may experience some residual unsteadiness, dizziness and occasionally nausea. I will not take any undisclosed medications or drugs prior to anesthesia. I will abstain from eating or drinking fluids for 6 hours prior to general anesthesia. I will not operate an automobile or dangerous equipment or machines for 24 hour following anesthesia.

Having been informed of the foregoing, I hereby consent to the administration of general anesthesia or sedation and the proposed treatment. I certify that I have read and fully understand all of the words and information contained in this form and that all blanks were filled in before I signed this document.

PATIENTS NAME:_____

DATE:_____TIME:_____SIGNATURE(Adult PATIENT or Guardian):_____

DATE:_____TIME:_____SIGNATURE(DOCTOR)_____

DATE:_____TIME:_____SIGNATURE(WITNESS):_____