CONSENT TO ORAL SURGERY
AND
ACKNOWLEDGMENT OF RISK INFORMATION

Patient:

What you are being asked to sign is simply an authorization which will allow Dr. Crowley, his assistants, or designees, as is necessary in his judgement, to perform the following treatment/procedure/surgery:

Dr. Crowley has discussed with you the advantages, alternatives and risks associated with the proposed treatment. We wish to inform you, not to alarm you, so that you may have sufficient information upon which to make a decision whether to have the treatment of your own free will. Please read this form carefully and ask about anything you do not understand.

I am advised that although good results are expected, the possibility and nature of the complication cannot be accurately anticipated and that therefore there can be no guarantee, either expressed or implied, either as to the result of the treatment or as to the cure.

I have been informed and understand that occasionally there are complications of the treatment, drugs and anesthesia, which may include the following:

- Swelling, bruising, discoloration; infection and/or delayed healing;

- Pain, discomfort and/or stiffening of the jaw muscles;

- Prolonged bleeding;

- Nausea and/or vomiting;

- Injury to adjacent teeth, and other tissues, fillings and crowns, and/or bone fractures;

- Sinus complications including sinus inflammation or persistent sinus opening;

- Temporomandibular joint difficulty (jaw joint);

- Thrombophlebitis (inflammation to a vein);

- Allergic reactions;

- Numbness and tingling of the lip, tongue, chin, gums, cheeks and teeth, which if present is usually temporary, but may be permanent;

I consent to administration of such local and/or general anesthesia as deemed necessary by Dr. Crowley and/or his designated assistants, to accomplish the proposed procedure. Medication, drugs, anesthetic and prescriptions may cause drowsiness and lack of awareness in coordination which can be increased by the use of alcohol or other drugs; thus I have been advised not to operate any vehicle or hazardous device or work while taking such medication and/or drugs or until fully recovered from the effects of the drug. I understand and agree not to operate any vehicle or hazardous device for at least twenty four (24) hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care.

I certify that I have read and understand this consent, that all questions about the surgical procedure or procedures have been answered in a satisfactory manner, and that all blanks were filled prior to my signature.

Patient:	Date
Relative (where required)	
Witness	

Maurice R. Crowley, D.M.D.
Oral/Maxillofacial Surgeon
402 Professional Arts Bldg.
New Albany, IN 47150
Phone: (812) 945-2760
Fax: (812) 945-2780