

**CONSENT TO ORAL SURGERY AND  
ACKNOWLEDGEMENT OF RISK INFORMATION**

Patient: \_\_\_\_\_

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

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/authorize this 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 complications cannot be accurately anticipated and therefore, there can be no guarantees, express or implied, as to the result of the treatment or the cure.

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

- SWELLING, BRUISING (CAN GO UP TO THE EYES AND AS FAR DOWN AS THE CHEEK, 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, OTHER TISSUES, FILLINGS AND CROWNS, AND/OR BONE FRACTURES
- SINUS COMPLICATIONS INCLUDING SINUS INFLAMMATION OR PERSISTANT SINUS OPENING
- TEMPOROMANDIBULAR JOINT DIFFICULTY (JAW JOINT)
- THROMBOPHLEBITIS (INFLAMMATION TO A VEIN)
- ALLERGIC REACTION
- NUMBNESS AND TINGLING OF THE LIP, TONGUE, CHIN, GUM, CHEEKS, AND TEETH. THIS IS OFTEN TIMES TEMPORARY BUT MAY BE PERMANENT.
- PATIENT TAKING BISPHOSPHONATES/CALCIUM REPLACEMENTS MAY EXPERIENCE NECROSIS OF UPPER OR LOWER JAW.

Anesthetic Risks: Included but are not limited to discomfort, swelling, bruising, infection, prolonged numbness and allergic reaction. There may be inflammation at the site of an intravenous injection, which may cause prolonged discomfort and/or disability that may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous Anesthesia is a serious medical procedure and, although considered safe, does carry with it the rare risks of heart irregularities, heart attack, stroke, brain damage or even death.

**Your obligation if General/IV Anesthesia is Used:**

1. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered and able to care for yourself.
2. During recovery time, (24 hours), you should not drive, operate complicated machinery or devices, or make important decisions such as signing contracts or other important documents.
3. YOU MUST HAVE A COMPLETELY EMPTY STOMACH. IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!!
4. It is important that you take any regular medications (high blood pressure, antibiotics, etc.) using only a small sip of water.

I consent to administration of such local and/or general anesthesia as deemed necessary by Dr. Homrighausen and/or his designated assistants to accomplish the proposed procedure. Medication, drugs, anesthesia 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 agree not to operate any vehicle/work while taking such medications until fully recovered from the effects of the drug.

ALTHOUGH GENERAL ANESTHESIA IS USED IN OUR OFFICE, I HAVE BEEN MADE AWARE TO THE FACT THAT ITS EFFECTS ARE DIFFERENT ON ALL PATIENTS. ALTHOUGH A PATIENT MAY APPEAR TO BE AWAKE, THEY ARE ASLEEP AND WILL NOT REMEMBER THE PROCEDURE. PATIENTS MAY SHOUT OR CRY OUT, YELL, CRY OR WHIMPER. AGAIN, THE PATIENT WILL NOT REMEMBER THIS. BECAUSE THIS IS OUTPATIENT SURGERY, SEDATION IS NOT AS DEEP AS IN A HOSPITAL SETTING. THIS IS FOR THE SAFETY OF THE PATIENT.

FOR PARENTS OF MINOR CHILDREN: I UNDERSTAND THAT AT THE POINT SURGERY BEGINS, I AM AT NO TIME ALLOWED IN THE OPERATING ROOM. I UNDERSTAND THAT THIS IS FOR THE SAFETY AND WELL-BEING OF MY CHILD.

PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

RELATIVE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

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