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CONSENT FOR OPERATION / PROCEDURE

I,…………………………………………………………………….Name of Patient/Parent/Guardian) NRIC:………………………………………hereby consent for:………………….............................. (Name of patient, Relationship to patient) to undergo the operation / procedure of Minor Oral Surgery for wisdom tooth removal.

Where the nature, effects of which, and the risks of the proposed and alternative course of action have been explained to me by Dr: …………………………………………………… personally or through the interpretation of : …………………………………………….. who has, to the best of his/her ability translated to me in the ……………………………… language/ dialect.

Risks/Complications of the recommended treatment :

1. Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side; this can persist for several weeks, months or, in rare instances, permanently
2. Postoperative discomfort, swelling, pain and bleeding that may necessitate several days of recuperation. Postoperative infection if any may require additional treatment.
3. Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint. In rare circumstances breakage of jaw.
4. Injury to adjacent teeth and fillings
5. A small piece of root left in the jaw when removal would require extensive surgery / root to be retained to protect the nerve.
6. Stretching of corners of the mouth with resultant cracking or ulcer.
7. Others

Alternative treatments:
There are many ways to treat dental problems. I have chosen the one that I think best suits your needs. However, there are other ways that your condition can be treated including taking medicine/ seeking specialist treatment/ no treatment.

Unforeseen conditions may arise during the procedure that require a different procedure than set forth above. I therefore authorize the Doctor to perform such procedures / alternative operation measures when, in their professional judgement, they are deemed necessary. I understand the nature, the risk of the recommended treatment and alternative treatment options.

Patient's Signature:………………………….. **Patient's Guardian's Signature:…………………………**
Name: **Name:**
Date: **Date:**

Doctor's Name:………………………………
Signature :
Date: