CONSENT FOR SURGERY

Date___________

Patient's Name_____________________

Procedure:

___Implant placement
___Free Gingival Graft
___Apicoectomy
___Flap Procedure
___Other___________
___Guided Tissue Regeneration
___Connective Tissue Graft
___Surgical Extraction
___Frenulectomy

Tooth Number/Quadrant__________

I hereby grant authorization to:

___Dr. Riaz M. Rayek, D.D.S., M.S.
___Dr. Tara L. Zier, D.D.S.
___Dr. Grace Lee, D.D.S.
___Dr. Nassir Barekzi D.D.S.

To administer any treatment, anesthetics, and to perform such operations as may be deemed necessary in the diagnosis and treatment of my dental needs.

We do our best to achieve the greatest result possible. On rare occasions, complications may occur. It has been explained to me that a perfect result cannot be guaranteed or warranted, and furthermore, **THAT THE PROCEDURE MAY INVOLVE THE POSSIBILITY OF THE FOLLOWING COMPLICATIONS:**

___Post-operative infection
___Bleeding
___Trismus (inability to open mouth)
___Injury to the adjacent teeth
___Soreness or discoloration at the injection site or along the vein
___Bruising
___Failure or rejection of implant, graft, etc.
___Antral communication (sinus involvement)
___Severe reaction to medication administered
___Alteration of the nerve sensation including numbness of the lip and/or tongue for an indefinite period of time or permanently.
___Other ____________________________________

I acknowledge that I have been informed of the risks and possible consequences of the operation proposed and do authorize the above named doctor(s) to proceed.

Signed:___________________________
(Patient, parent, or legal Guardian)

Date:_______________Doctor/Assistant signature:_________________________