Wholehearted Dental

400 - 1770 West 7th Ave.
Vancouver, BC V6J4Y6

604-733-9311
wholehearteddental.com

Informed consent for oral surgery

1. Consent

I authorize Dr. _____ and the clinical team at Wholehearted Dental to perform the following treatments:

_____

as explained to me, and/or any additional procedures deemed necessary to ensure my safety and complete the treatment.

2. Understanding of Procedure and Risks

I understand that the proposed procedures are intended to treat diseased oral or maxillofacial tissues and/or to remove teeth. I have been advised that without treatment, my condition may stay the same or worsen, and could lead to risks including: swelling, pain, infection, cyst or tumour formation, periodontal (gum) disease, dental decay, malocclusion (bite changes), jaw fracture, premature tooth loss, and/or bone loss.

I have also been informed of alternative treatment options, if any are available.

3. Normal Sequelae (Expected After-Effects)

I understand that it is common to experience one or more of the following after oral surgery:

- Discomfort and swelling requiring several days of rest and recovery
- Bleeding that may be prolonged and require additional care
- Infection requiring further treatment
- Temporary restriction in mouth opening
- Bruising of skin and gums
- Delayed healing or “dry socket,” which may cause pain

4. Possible Complications

Although rare, I understand there are potential complications, which may include:

- Nerve injury resulting in temporary or, in rare cases, permanent numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue
- Damage to adjacent teeth, fillings, bone, or gums
- Retention of a small root fragment if removal would require extensive surgery
- Opening of the sinus (a normal cavity above the upper teeth) that may require additional care
- Other: _____

5. Medication and Recovery

I understand that medications, anaesthetics, and sedatives may cause drowsiness, reduced awareness, and impaired coordination, especially if combined with alcohol or other substances. Therefore:

- I will not drive, operate machinery, or perform hazardous activities until fully recovered.
- If sedation is administered, I will not drive for at least 24 hours after surgery and will ensure a responsible adult accompanies me home.

6. Cooperation

I agree to follow post-operative instructions provided by the dental surgeon and to attend all recommended follow-up visits. I understand that failing to follow these instructions may delay healing or affect treatment outcomes.

7. Patient Acknowledgment

I certify that I have read and fully understand this consent form and the explanations provided to me. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (print): _____ Signature (Patient/Guardian): _____

Witness Name (print): _____ Signature (Witness): _____

Date: _____