Please read this informed consent carefully! **Jerry Minsky, DDS, Phone 562-860-8330, fax 714-363-5441**

1. This is my consent for my attending doctor and/or any oral and maxillofacial surgeon, physician, or dentist working with him/her to perform the following treatment procedure and/or surgery: **X-rays, examination, prophylaxis, periodontal (gum and bone) procedures , extractions, fillings, root canals, fixed and removable prosthetics (crowns and dentures), photos, biopsies, study models, and any necessary emergency treatment previously explained to me, or other procedures deemed necessary or advisable to complete the planned treatment.**
2. I understand that the purpose of the treatment, procedure, surgery, is to treat and possibly correct my diseased oral, maxillofacial and/or dental tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral and/or health condition may worsen in time, and the risk to my health may include, but are not limited to the following: swelling, pain, infection, cyst formation, periodontal (gum) diseases, dental caries (decay), malocclusion (an undesirable change in the way teeth bite together), pathologic fracture of the jaw (caused by the disease), premature loss of teeth and/or premature loss of bone, other bodily harm, or death. I have been informed of the possible alternatives of treatment, if any, as well as the risks and complications of alternative treatment.
3. My attending doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to:
   a. Postoperative discomfort and swelling that may necessitate several days of home recuperation.
   b. Heavy bleeding that may be prolonged,
   c. Injury to adjacent teeth and fillings/restorations.
   d. Postoperative infection requiring additional treatment.
   e. Stretching of the corners of the mouth with resultant cracking and bruising.
   f. Restricted mouth opening for several days or weeks.
   g. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
   h. Breakage of the jaw or other bone fractures.
   i. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months, or, in remote instances, permanently.
   j. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
   k. If intravenous medication is used, soreness at the injection site or along the vein may develop as well as some discoloration of the injection site.
   l. Pain and injury to, and suffering of neck and facial muscles.
   m. Change in the occlusion (biting) of the teeth.
   n. Changes to the temporomandibular joint and its ligaments. This is the joint that connects the lower jaw to your head.
   o. Injury to other tissues.
   p. Pain to the ear, head, neck, teeth, and oral tissues.
   q. Nausea, vomiting, allergic reactions, and bruises.
   r. Delayed healing.
   s. Side effects from any medications or anesthetic including death.
4. It has been explained to me that during the course of the procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s), or different procedure(s) than those set forth in paragraph one (1). I therefore authorize and request that such procedures as are necessary and desirable be performed in the exercise of professional judgment. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.

______________________________ Patient (Please Print): ______________________________

Doctor (Please Print) Jerry Minsky, DDS Name of Signer (Please Print): ______________________________

Doctor's Signature: ______________________________ Signature and Date/Time of Signer: ______________________________

Witness and/or Translator: ______________________________ Relationship to Patient: ______________________________

Patient Name ______________________________

5. I consent to administration of such local, intravenous, intramuscular, oral, subcutaneous, and/or inhalation medication as deemed necessary to accomplish the proposed procedure.
6. Medication, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile, or hazardous devices; or work, while taking such medications and/or drugs; or until fully recovered from the effects of same. I understand and agree not to operative any vehicle or hazardous device for at least twenty-four (24) hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery if I am receiving intravenous medication or general anesthetic, and will have a responsible adult drive me home after discharge.
7. I agree to cooperate completely with the recommendations of my attending doctor while I am under his/her care, realizing that any lack of same could result in a less than optimum result,
8. I have had an opportunity to discuss my past medical health history including any serious problems, diseases, and injuries with my attending doctor.
9. I understand that there are certain inherent and increased risks with intravenous medications and general anesthetics, which could involve serious bodily injury or death.
10. I understand there is no warranty or guarantee as to the result and/or cure, and that my condition may return or become worse.
11. I have been told of the consequences of no treatment,
12. I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITH THE ABOVE CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN, AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE THAT I READ, WRITE, AND UNDERSTAND ENGLISH, OR THAT LANGUAGE ASSISTANCE WAS USED. I FURTHER STATE THAT I HAVE NOT WITHHELD ANY INFORMATION RELEVANT TO MY MEDICAL AND DENTAL HISTORY AND THAT I HAVE PROVIDED ACCURATE INFORMATION ON MY MEDICAL AND DENTAL HISTORY. I HAVE ALSO RECEIVED A SIGNED COPY OF THIS FORM.

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Patient (Please Print): ____________________

Doctor (Please Print) Jerry Minsky, DDS

Name of Signer (Please Print): ____________________

Doctor's Signature: ____________________

Signature and Date/Time of Signer: ____________________

Witness or Translator: ____________________

Relationship to Patient: ____________________

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Patient Name