Patient Name: _____

Date of Birth: _____

Informed Consent for Orthognathic Surgery

I. Recommended Treatment

I hereby give consent to Dr. _____ to perform Orthognathic Surgery procedure(s) on me or my dependent as follows: _____

_____ ("Recommended Treatment") and any such additional procedure(s) as may be considered necessary for my well- being based on findings made during the course of the Recommended Treatment. The nature and purpose of the Recommended Treatment have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with the Recommended Treatment. I also consent to the administration of local anesthesia during the performance of the Recommended Treatment.

II. Treatment Alternatives

Alternative methods of treatment have been explained to me, such as: _____

_____

but I wish to proceed with the Recommended Treatment described above.

III. Risks and Potential Complications

I understand that there are risks and potential complications associated with the administration of medications, including anesthesia, and performance of the Recommended Treatment. These risks and potential complications, include, but are not limited to, the following:

1. Post-operative pain, bleeding, oozing, soft tissue infection and/or bone infection.
2. Bruising and/or swelling, restricted mouth opening for several days or weeks, or, rarely, longer.
3. Loss or removal of bone during and/or following surgery.
4. Damage to, or fracture of, teeth or tooth restorations, possibly resulting in tooth loss.
5. Delayed healing, necessitating post-operative care.

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6. Possible involvement of the sinus during upper jaw procedures, which may require additional treatment or surgical repair at a later date.

7. Possible injury of the nerves of the lower jaw during lower jaw procedures, resulting in temporary or permanent tingling/numbness/pain (possibly of an electric shock nature) of the lower lip, chin, tongue or other surrounding structures, with potential alteration or loss of taste. Depending upon the specific procedures performed, such injury may be expected.

8. Nasal septum deviation, which may require treatment.

9. Possible need to wire or otherwise affix the jaws to each other, or possible need to maintain the wiring/affixing longer than anticipated.

10. Need to surgically remove wires, plates, and/or screws placed into or near bone.

11. Prolonged hospitalization.

12. Relapse, or a tendency toward relapse, from the location of the surgically positioned bone segments toward their initial position, possibly requiring additional surgery and/or orthodontics.

13. Need for orthodontics, which may be for a prolonged period of time.

14. Bite/occlusion alterations.

15. Alterations in the ability to eat and/or drink.

16. Weight loss.

17. Lost work/school time.

18. If you are taking medications to make your bones stronger (such as bisphosphonates) or if you have received radiation therapy to the head or neck area for tumors/cancer, then you are at a higher risk for poor bone healing or bone loss that may never completely resolve and which may require surgery or other treatment.

19. As a result of the Lidocaine injection or use of other local anesthesia, there may be swelling, jaw muscle tenderness or even resultant tingling/numbness/pain (possibly of an electric shock

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nature) of the tongue, lips, teeth, jaws and/or facial tissues, which is typically temporary, but in rare instances, may be permanent; this may include alteration or loss of taste.

20. Pain and/or limited movement of the jaw joint, either of a temporary or permanent nature, which may require further treatment.

Signature: _____ Date: _____

Patient/Parent/Guardian

Relationship (if patient a minor): _____

Witness (signature): _____