ASSOCIATES IN DENTISTRY

IMPLANTS
&
General Dentistry

CONSENT FOR ORAL SURGERY

I, _____ hereby authorize Dr. Zubkov, or designated associates and assistants to perform the following dental surgical procedures on me under local anesthetic:

Tooth # _____

The nature and purpose of the procedure (s) as well as the therapeutic alternatives have been explained to me. Dr Zubkov and his team have fully explained to me what will happen during the procedure and have answered all of my questions. Specifically the risks and/or complications of dental surgery (extractions or periodontal bone surgery) may include: Swelling after surgery, Infection, Bleeding, Recurrence of periodontal defect and/or infection, Gum/Gingivial recession, Perforation into the sinus (upper arch only), Dry Socket, Transient or permanent paresthesia after extraction (persistent numbness) at site of procedure or the same side of the face.

_____ _____

Patient Signature Date

_____ _____

Signature of Person Authorized to consent for patient Date

_____ _____

Witness Date