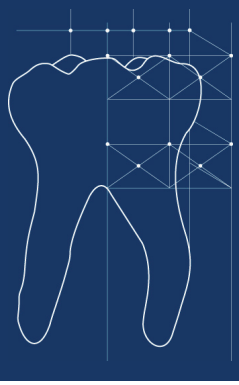

ORAL/MAXILLOFACIAL SURGERY CONSENT

What you should know about this procedure

Oral Sx

Chavis Dental

1145 19th Street NW • Washington, DC 20036 • Tel: 202-833-3377

1. I hereby authorize Dr. Cary T. Chavis to perform the following treatment, procedure, or surgery:

_____

as previously explained to me or other procedures deemed necessary or advisable to complete the planned operation.

2. I understand that the purpose of the procedure is to treat and possible correct my diseased oral/maxillofacial tissues. Dr. Chavis has advised me that if this condition persists without treatment, my present oral condition may worsen in time, and the risks to my health may include but are not limited to the following: swelling, pain, infection, cyst formation, periodontal (gum) disease, dental caries (cavities); malocclusion (bad bite), pathologic fracture of the jaw, and loss of teeth and/or bone. I have been informed of possible alternative methods of treatment, if any.

3. Dr. Chavis has explained to me that there are certain risks in any treatment plan or procedure. These operative risks include, but are not limited to: postoperative discomfort and swelling that may necessitate several days of recuperation at home; dry socket; prolonged bleeding; injury to adjacent teeth and restorations; infection requiring additional treatment; stretching of the corners of the mouth; with resultant cracking and bruising; restricted mouth opening for several days or weeks; decision to leave a small piece of root in the jaw when its removal would require extensive surgery; breakage of the jaw; injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, tongue, chin, gums, cheek, and/or teeth on the operated side, which may persist for weeks, months, or in remote instances, permanently; opening into the maxillary sinus cavity which may require additional surgery; soreness and discoloration at the intravenous injection site, or along the vein; cardiac arrest.

4. I consent to the administration of such local anesthetic as deemed advisable by Dr. Chavis to accomplish the proposed procedure.

5. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol and/or other drugs; thus, I have been advised NOT to operate any vehicle, automobile, hazardous device, or work while taking such medication and/or drugs or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office for my care.

6. I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted. Due to the individual patient differences there exists risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is Dr. Chavis's opinion that therapy would be helpful.

7. I agree to cooperate with the recommendations of Dr. Chavis while I am under his care, realizing that any lack of cooperation could result in less than an optimum result.

I certify that I have read and fully understand the terms and words within the above consent to the operation and to the explanations referred to or made. I have had an opportunity to ask Dr. Chavis any questions regarding the proposed treatment. I also certify that I read and understand English.

Name of Patient (Please Print) _____ (Patient/Parent/Guardian) Signature _____

Date _____ Doctor _____ Witness _____