HILLTOP DENTAL

Hilltop Dental Associates, P.C.

1736 Lyter Drive
Johnstown, PA 15905
Office: (814) 255-6831
Fax: (814) 254-1521
SrokaDental.com

Gary A. Minchau, D.M.D. Matthew R. Sroka, D.M.D.

Consent to Operation or Other Procedures

I,_____ , hereby authorize and request that Dr. Gary Minchau, Dr. Matthew Sroka, their assistants, and their designees perform such procedure(s) as are necessary and desirable in their professional judgment to treat my oral and maxillofacial problem or condition.

I am aware that there are risks and possible undesirable consequences associated with the treatment of my oral and maxillofacial surgical problem including severe life threatening complications.

Following surgery, it may be necessary to reduce (trim) the bone so as to remove sharp areas, which develop during healing. Possible complications following oral and maxillofacial surgical procedures (i.e. – removal of teeth, administration of local anesthesia, etc) includes but is not limited to:

- Pain
- Bleeding
- Swelling
- Infection
- Discoloration – bruising
- Lip, tongue, chin, gums, cheeks, and teeth numbness (may be permanent)
- Changes in occlusion (bite) or temporomandibular joint difficulty
- Painful socket (dry socket requiring packing with medication)
- Allergic reaction
- Nausea and vomiting
- Sinus involvement
- Fracture of the jaw
- Retained root
- Phlebitis (inflammation of veins)
- A second operative procedure
- Sore throat
- Injury to and stiffening of neck and facial muscles
- Delayed healing
- Lacerations, scars or retraction marks
- Referred pain to ear, neck, and head
- Injury to or loss of other teeth (including filling, crowns, and bridges)

I understand the document and hereby give my informed consent.

_____ _____

Signature of Patient/Parent Date

_____ _____

Witness Closest relative or legal guardian