Consent for Removal of Cyst or Tumor

Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

Your diagnosis is: _____
Your planned procedure is: _____
_____
Alternative treatment methods include:_____
_____

Removal of a cyst or tumor (growth) from the jaw, whether easy or difficult, is still a surgical procedure. All surgeries have some risks and those may include any of the following:

1. Swelling, bruising, and pain.
2. Stretching of the corners of the mouth that may lead to cracking or bruising.
3. Infection that might require more treatment.
4. Loss of nerve or blood supply to teeth which might result in root canal treatment or loss of the teeth.
5. Extensive or severe bleeding.
6. Injury of nerves which might result in numbness or change in feeling in the lips, chin, cheek, nose, tongue, teeth, or gums which could be permanent.
7. In the case of tumors, resection (removal) of part or all of a nerve may be necessary, and this would result in permanent loss of feeling or pain.
8. Nerve grafting may be performed at the time of surgery, or at a different surgery, to repair an injured nerve.

9. In the case of certain tumors, incisions in the skin of the face or neck may be necessary and may result in a noticeable scar; and could also result in injury to nerves which control muscle movement of the face.

10. Bone grafting to replace bone removed with the surgery may be performed at the time of surgery, or at a later date.

10. Dental implants and/or dental prostheses (bridges, etc.) to replace teeth lost in treatment might be needed at a later date.

11. In cases involving the lower jaw, the jaw might break at the time of surgery, or days or weeks after surgery. Repair of the fracture may involve bone grafting, wiring or use of metal plates and screws.

12. The tumor or cyst might come back and need additional surgery.

13. Follow-up visits and additional x-rays will be necessary to evaluate healing and to look for any return of the cyst or tumor. I agree to return for visits as required by Dr. _____, or other Oral and Maxillofacial Surgeons involved in my care.

CONSENT

If my doctor finds a different condition than expected and feels that a different surgery or more surgery needs to be done, I agree to have it done.

I understand that my doctor can't promise that everything will be perfect. I have read and understand the above and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

_____

Patient's (or Legal Guardian's) Signature Date

_____

Doctor's Signature Date

Witness' Signature Date