

I understand that the Treatment of Post-Operative Complications, such as dry socket is to aid in the comfort of the healing process, it is not the healing process itself. I understand treatment of dry socket is not required for the body to heal but will greatly aid in the comfort of the patient during the healing process. I understand that even though care and diligence is exercised these treatments have limitations and risks and absolute success cannot be guaranteed. Nevertheless, I agree to assume the risks, possible unsuccessful results and/or failure associated with, but not limited to the following:

Dry socket occurs when the blood clot is dislodged from the surgical extraction site. The dislodgement exposes the bone underneath to oxygen and the bone tissue dies. The pain most commonly referred to as Dry Socket is caused by the dead bone tissue. Clots can dislodge on their own however are most often dislodged due to a patient's lack of adhering to post-operative instructions, such as sucking on a straw or smoking.

1. Placement of Material: In order to relieve the discomfort associated with dry socket, a medicated dry socket pack is placed over the surgical site. Before the material can be placed the socket may need to be rinsed with water by the doctor to clear any foreign bodies or bits of food. This procedure may cause mild pain or discomfort.

2. Dislodgement of Bone Spicule: As the body heals after being treated for dry socket it is possible for small fragments of bone, often called bone spicules, to become dislodged. This occurs due to the tissue forming underneath the dead/exposed bone to protect the healthy bone. These spicules are relatively harmless, however should a large portion of bone be dislodged this office and/or the patients oral surgeon should be contacted immediately.

3. Response to Treatment: Because of many variables within each patient's physiological make-up, it is impossible to precisely determine whether or not the healing process, in which tissue response is a vital element, will achieve the results desired by the attending dentist and hygienist as well as the patient.

4. Unusual Reactions to Medications Given or Prescribed: Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It is important to take all prescription drugs according to instructions. If an allergic reaction or other physical reaction occurs the patient must notify this office as soon as possible. If symptoms are severe the patient should seek medical attention first and then notify this office.

I understand that it is my responsibility to notify this office should any undue or unexpected problems occur or if any problems relating to the treatment rendered are experienced.

Informed Consent: I have been given the opportunity to ask any questions regarding the nature and purpose of **Treatment of Post-Operative Complications** and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning my recovery and results of the treatment. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize this practice and/or their associates or agents to treat my postoperative complication and/or dry socket as deemed appropriate and/or advisable to my dental condition, including prescribing and administering appropriate anesthetics and/or medications. I understand it is my responsibility to notify the dentist and/or his associates of ALL the medications I am currently taking.

Post-op Complications Consent

Patient: Submitted: 10/2/2024

Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. It is my responsibility to inform the dental office of any changes in medical status.

I consent to use Electronic Records and Signatures.: []

Relation to Patient:

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

I consent to use Electronic Records and Signatures.: []