Centrum Dental Centre
Consent for Surgical Gum Treatment

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment.

Proposed Treatment: _____
Reason for Treatment: _____

The doctor has explained to me that there are certain potential risks in this treatment plan or procedure. These include but are not limited to:

1. Postoperative infection requiring additional treatment.
2. Restricted mouth opening for several days.
3. Postoperative discomfort, swelling, and bleeding that may necessitate several days of recuperation.
4. Stretching of the corners of the mouth with resulting cracking and bruising.
5. _____
   _____
6. _____
   _____

Unforeseen conditions may arise during the procedure that require a different procedure than set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary.

I understand that the medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects.

It has been explained to me and I understand that a perfect result is not guaranteed or warrantied.

Please do not hesitate to ask the doctor or staff if you have any questions.

_____ _____
Patient (PRINT) Signature

_____ _____
Doctor Date