Dr. Purnima Hernandez & Dr. Selin Soyupak
23-00 Route 208, Suite 2-5,
Fair Lawn, NJ, 07410

Informed Consent

I, ________________________________ give my consent for Dr. ___________ to perform the following treatment/procedure ____ on (Patient's name) ____________________________ previously explained to me or other procedures deemed necessary or advisable to complete treatment.

I understand that the purpose of the procedure/treatment is to treat and possibly correct the diseased oral/maxillary tissues. The benefits derived from this procedure/treatment as well as the alternative to NO treatment have been explained to me.

I have been informed and understand that there are inherent risks and/or complications of the treatment, drugs and or anesthesia, including: **pain, swelling, discoloration, bleeding, infection, numbness, tingling, or stiffness** of the jaw muscles; referral pain to adjacent structures such as the ear or cheek; temporomandibular joint (TMJ) difficulty, possibility of **small root fragments remaining in the jaw,** when their removal would require extensive surgery, and finally **damage to adjacent structures** such as teeth, fillings, crowns and/or gums. Complications might include **nausea or vomiting, allergic reaction, bruises, delayed healing, sinus involvement** requiring a secondary surgical procedure, and/or **devitalization** of adjacent teeth requiring root canal.

Women, the effectiveness of birth control pills may be interfered with the use of antibiotics and other medications.

Certain possible risks exist that although uncommon, could include nausea, pain, swelling, inflammation and/or bruising at the injection site. Rare complications include allergic or unexpected drug reactions, pneumonia, heart attack, stroke, brain damage, and/or death. Medications, drugs, anesthetics or prescription medications may cause drowsiness and lack of coordination, which is made worse with consumption of alcohol or other drugs.

I consent to the performances of the treatment and procedures in addition to, or different from those not contemplated, whether arising from presently unforeseen conditions which the above named doctor, and his/her associate or assistant, may consider necessary or advisable in the course of treatment.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO THE TREATMENT, ALL STATEMENTS MADE THEREIN ARE TRUE, AND ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE PROPERLY COMPLETED BEFORE I SIGNED.

________________________________ ________________________________

(PATIENT/GUARDIAN SIGNATURE) (DATE)

When a patient is under18 years of age (with the exception of emancipated minors) or is incompetent to give consent. I hereby certify that I have explained to the patient/relative or guardian in plain language the nature, purpose, benefits, risks of, and alternative to the proposed procedure/treatment, have offered to answer any questions and have fully answered any questions and have fully answered such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Physician:____

(Signature) (Print) (Date)