MAINE DEPARTMENT OF CORRECTIONS

CONSENT TO INVASIVE DENTAL PROCEDURES, INCLUDING SURGERY

RESIDENT NAME: MDOC #: DOB:

My condition has been explained as:

I consent to , D.D.S./D.M.D. and their associates and assistants as they may deem necessary to direct and perform the following procedure(s):

If, during the course of the procedure(s), the discovery of unforeseen conditions requires, in the judgment of the provider(s) described above, different procedure(s) than those proposed, I consent to such different procedure(s) as are deemed appropriate.

I understand that no promise has been made to me regarding the outcome of the procedure(s), the cure of any condition, or the risks presented by the procedure(s). The risks presented by the procedure(s) have been explained to me and include, but are not limited to:

- Postoperative discomfort and swelling
- Prolonged or heavy bleeding that may require additional treatment
- Postoperative infection that may require additional treatment
- Allergic reactions (previously unknown) to any medication used in treatment
- Injury or damage to adjacent teeth or fillings
- Stretching the corners of the mouth, which may cause cracking or bruising and may heal slowly
- Restricted mouth opening during healing, sometimes relating to swelling and muscle soreness, and sometimes related to stress on the jaw joints, especially when TMJ problems already exist
- A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications
- Fracture of the jaw (usually only in more complicated surgery)
- Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling, or other sensory disturbances in the chin, lip, cheek, gums or tongue, which may persist for several weeks, months or in rare situations, permanently
- Opening of the sinus (a normal chamber situated above the upper teeth) requiring additional surgery or treatment
- Dry socket (loss of blood clot from extraction site)

I have been informed of possible alternative treatment (if any), including:

I further understand that these other forms of treatment, or no treatment at all, are choices that I have, and the risks of those choices have been presented to me.

If applicable, I consent to the administration of anesthesia and to the use of such anesthetic agents and as many other drugs as deemed necessary and advisable and understand that anesthesia and other drugs present additional risks. Common side effects include nausea, sore throat, chills, grogginess, and fatigue. Rarely, there can be more serious risks.

I consent to the disposal of any tissues, teeth, etc. which may be removed as a result of the procedure(s).

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I have been given the opportunity to ask questions about my, or the patient's condition, its nature and duration, the proposed diagnostic and/or treatment procedure(s), alternative procedure(s) and forms of anesthesia, risks of non-treatment, and benefits and risks of the proposed procedure(s).

I release the Maine Department of Corrections, its contracted health care services provider, their employees, and their agents from any and all liability which may arise from this action.

I have read, or have had read to me, this form and acknowledge that I understand its contents and I am signing it voluntarily.

_____	_____
Resident Signature	Date

_____	_____	_____
Guardian Name (where applicable) (Print)	Guardian Signature	Date

_____	_____	_____
Witness (Print)	Witness Signature	Date

I have explained the matters indicated above relating to the procedure(s) and the risks, benefits and alternatives. The resident appeared to understand and consented to the procedure(s) described.

_____	_____	_____
Health Care Provider Name (Print)	Health Care Provider Signature	Date