WISDOM TEETH REMOVAL
CONSENT FORM

Patient: _____

I herby consent to the removal of my wisdom teeth, which will be performed by **Dr. Amir Guorgui**, General Dental Surgeon.

I am satisfied that I fully understand the nature and purpose of the treatment.

I agree to use the type of anesthesia and/or sedation that has been explained to me.

I understand that if during the course of treatment any procedure different from that now authorized should be indicated and is justified to be in my best interest it will be carried out by the practitioner.

I agree to follow post-operative instructions to the best of my ability for my own comfort and safety.

I understand that discomfort, bleeding, swelling, bruising, infection, injury to adjacent teeth and restricted mouth opening, are possible normal consequences to any oral surgery procedure.

I understand and accept the possible complications as explained to me by Dr. Guorgui. These may include but are not limited to:

- Injury to nerves of the lower lip and tongue leading to numbness, which could possibly be permanent
- Involvement of the sinus above the upper teeth
- Fracture of the jaw

I understand that all fees incurred for my appointments with Dr. Guorgui must be paid in full at my scheduled visits. We will gladly submit insurance claims on your behalf and you will be reimbursed directly from your insurance company.

I understand that if I cancel this appointment without a one-week notice, a cancelation fee will be charged to me directly, this is not covered by any insurance.

I certify that I have read and fully understand the above consent of treatment, and I am fully satisfied with the explanations given to me by Dr. Amir Guorgui

_____ _____

Patient's or legal guardian's signature Date

I confirm that I have explained the treatment and type of anesthetic and/or sedation proposed to the patient to the best of my knowledge and judgment.

_____ _____

Doctor's signature Date