CONSENT FOR TEMPOROMANDIBULAR JAW JOINT SURGERY

____
Patient's Name   Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be given information about your proposed surgery so that you can make an informed decision whether to proceed. What you are being asked to sign is your acknowledgement that you understand the nature of the proposed treatment, the known risks associated with it and the possible alternative treatments. Questions you have are important and should help you understand all the risks and benefits, so please ask about anything you do not understand.

_____1. I authorize my doctor and staff to treat the condition diagnosed as: _______________
____

I understand that my condition of limited or compromised function and joint noise may be due to several causes including traumatic injury, articular disc displacement, developmental defect, degenerative joint disease, inflammation, arthritis, infection, or damaging habit patterns. I realize that some of these conditions may continue in spite of the satisfactory completion of the proposed procedure.

_____2. The procedure planned to treat the condition noted above has been explained to me and I understand it to be:____
____

_____3. Other options/alternatives to the proposed procedure include no treatment at all or:___
____
____

I understand these options, including the risks and rewards of each and I wish to proceed with the recommended surgical procedure.

_____4. The proposed surgery has been outlined for me in laymen's terms and possible complications and side effects have been discussed, including, but not limited to:

_____ A. Objectionable scarring of the incision line, possibly requiring later revision.
_____ B. Post-operative swelling, bruising of the area, hematoma (blood clot) formation and discomfort.
_____ C. Wound infection.
_____ D. Foreign body reaction and, if used, rejection of implant materials.
_____ E. Malocclusion (change in bite) after surgery.
_____ F. Post-operative development of adhesions (scarring) within the joint space that may cause continued jaw dysfunction and decreased range of jaw movement or difficulty chewing.
_____ G. Facial muscle weakness, particularly of the forehead and eyelid, or inability to close the eye tightly on the affected side, which is caused by injury to the motor nerves in the immediate surgical area. Such complications could be permanent.

_____ H. Ear problems, including infection of external, middle or inner ear; or temporary or permanent hearing loss, ringing in the ears or equilibrium problems.

_____5. I understand that additional post-operative treatment may be necessary, including physical therapy, splint therapy, reconstructive dentistry, orthodontics, jaw repositioning therapy, removal of certain devices or further joint surgery, including total joint replacement.

_____6. I understand that this is complex surgery, and there can be no guarantee of complete resolution of my present symptoms or jaw dysfunction. Occasionally there may be increased post-operative symptoms.

_____7. Recognizing that during surgery some unforeseen condition may be discovered that might necessitate a change in approach or different procedure from those explained above, I authorize my doctor to perform such procedures as are necessary and advisable in the exercise of his professional judgment.

_____8. I understand that general anesthesia will be used for my surgery and there is risk of serious bodily injury inherent in such anesthesia, including death. I have been told not to have any food or drink for **SIX (6) hours** prior to my anesthetic (including water, coffee or tea) and that **CONSUMING FOOD OR DRINK BEFORE ANESTHESIA MAY CAUSE LIFE-THREATENING COMPLICATIONS**.

_____9. I have discussed my past medical history with my doctor and have disclosed all diseases and medications, including past and present alcohol and drug use.

_____10. I agree to cooperate completely with the recommendations made by my doctor, realizing that lack of cooperation may result in a less-than-optimal result. I have not been given any warranty or guarantee as to the result of the proposed procedure.

CONSENT

I certify that I have had an opportunity to read and fully understand the terms within the above paragraphs and that all blanks were filled in prior to my signing this form. All my questions have been answered to my satisfaction and I am willing to undergo the proposed surgery. I also certify that I speak, read and write English.

____
Patient's (or Legal Guardian's) Signature Date

____
Doctor's Signature Date

____
Witness' Signature Date