Alex McMillan IV, D.D.S. & Associates
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CONSENT FOR SURGERY

Date_____
Patient Name_____
Procedure:

___ Implant Surgery
___ Sinus Evelation/LeFort Elevation
___ Connective Tissue Graft
___ Bone Graft
___ Surgical Extraction
___ Frenulectomy
___ Laser Flap Procedure
___Guided Tissue Regeneration
___ Free Gingival Graft
___ Bone Graft
___ Apicoectomy
___ Flap Procedure
___ Soft Tissue Allograft
___ Other

Tooth Number/Quadrant_____

I hereby grant authorization to:

___ Dr. Alex McMillan IV
___ Dr. Robert Murfree
___ Dr. _____

To administer any treatment, anesthetics, and to perform such operations as may be deemed necessary in the diagnosis and treatment of my care.

We do our best to achieve the greatest result possible. However, complications can occur, although highly unlikely.

It has been explained to me, and I understand, that a perfect result is not always guaranteed or warranted and cannot be guaranteed, and furthermore, THAT THE PROCEDURE MAY INVOLVE THE POSSIBILITY OF THE FOLLOWING COMPLICATIONS:

___ Post-operative infection
___ Bleeding
___ Trismus (inability to open mouth)
___ Soreness or discoloration at the injection site or along vein may develop
___ Bruising
___ Failure or rejection of implant, graft, etc.
___ Need for future endodontic care
___ Antral communication (sinus involvement)
___ Severe reaction to drug administered
___ Alteration of the nerve sensation including numbness of the lip and/or tongue for an indefinite period of time or permanently.
___ Other_____

I acknowledge that I have been informed of the risks and possible consequences of the operation proposed and do authorize the above named doctor (s) to proceed.

Signed:_____ Date:_____
patient or nearest relative in the case when the patient is a minor or physically or mentally challenged

Doctor/Assistant signature:_____