OKLAHOMA DEPARTMENT OF CORRECTIONS
CONSENT FOR DENTAL TREATMENT

Facility: _____ Date: _____ Time: _____

I hereby authorize _____ and assistant(s) to perform the following operation, procedure or treatment:

Diagnosis: _____

Procedure:

_____

Tooth Number(s) and Description:

_____

Alternative options:

_____

1. I have been informed of and understand the potential risks related to this surgical procedure include but are not limited to:

   Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials; nerve injury resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). In some cases may be permanent.; dry socket (slow healing) resulting in jaw pain that increases a few days after surgery; sharp ridges or bone splinters may form where the tooth was removed possibly requiring additional surgery; part of the tooth and/or roots may be left to prevent damage to nerves or other structures; an opening (sinus perforation) may occur from the mouth into the nasal or sinus cavities and may require additional surgery.

2. I have been informed of and understand the potential risks associated with anesthesia include but are not limited to: Nerve injury resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent. Allergic or adverse reactions to medications or materials, pain, redness, irritation, bruising, swelling, nausea, vomiting, disorientation, confusion, lack of coordination, drowsiness, overdose, heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest) or death.

3. I have been informed of and understand that additional visits, evaluation, treatment or surgery, and/or hospitalization may be needed.

4. I have been informed of and understand that ODOC policy does not allow for the replacement of teeth removed today.

5. I have been informed of and understand that no guarantee or assurance has been made as to the desired result that may be obtained.

6. If any unforeseen condition arises in the course of the operation, procedure or treatment calling for the judgement of the provider in addition to or different from those now contemplated, I further request and authorize the provider to do whatever is deemed necessary.

<u>Patient's Responsibilities</u>:

I have been informed of my diagnosis, the planned procedure, and the risks, benefits, and alternatives associated with the procedure. I have provided an accurate and complete medical history, including all past and present dental/medical conditions, prescription and non-prescription medications, any allergies, recreational drug use and pregnancy (if applicable). I understand the use of tobacco and alcohol is detrimental to the success of my treatment. I agree to follow all instructions provided to me by this office, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications, risks, or less than optimal results. I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read (or have had read to me) this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

Please check one of the boxes below which describes your situation:

☐ I have read and fully understand the terms of this consent and acknowledge that the explanations referred to were made and that all blanks have been filled.

OR

☐ I do not speak or read English and an interpreter has explained this consent to me. I fully understand the terms of this consent and acknowledge that the explanations referred to were made and that all blanks have been filled.

Name of Interpreter _____ Signature of Interpreter_____

Inmate's Signature_____ Date_____

Witness's Signature_____ Date_____

I certify that I have explained to the patient the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient fully understands what I have explained.

Doctor's Signature_____ Date_____

Inmate Name ODOC Number

(Last, First)

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