

Informed Consent for Biopsy

Purpose of Biopsy: I understand that my dentist has recommended that I undergo a biopsy involving partial or complete removal of the lesion in the area of _____. The purpose is to diagnose the lesion type. The diagnosis will determine what follow up care, if any, is required.

Choosing not to Proceed: I was informed that if I choose not to proceed with the biopsy that I risk the worsening of an undiagnosed problem which may impact my oral and general health. Consequences may include, but are not limited to, persistence and possible growth of the lesion.

Surgical Procedures: I understand that the Biopsy may involve some or all of the following:

- Use of Local anesthetic, oral or intravenous conscious sedation analgesics and sutures (stiches).
- Additional procedures during the biopsy, which are not known to be needed at this time.
- Performance of diagnostic studies relating to my biopsy will be performed by other medical/dental professionals.

Risk and Complications of Biopsy: I understand that the risks and complications associated with the biopsy include but are not limited to:

- Need for additional surgery or referral to another specialist
- Scarring
- Allergic reactions to dental materials/medications
- Bleeding, Swelling, and/or Infection
- Pain and/or tooth sensitivity
- Exposure of root surfaces (recession)
- Exposure of gaps between the teeth, exposure of crown and bridge margins
- Temporary restriction of mouth opening
- Possible altered or loss of sensation due to dental nerve damage (teeth, gums, lips, tongue, cheeks, face, palate...)
- Increased tooth sensitivity

Risks and Complications of local anesthetic use: I understand that the risks and complications associated with the use of local anesthetic include, but are not limited to: Never injury, which may occur from the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheeks, lips, chin, teeth, gums and/or tongue (including loss of taste). Such conditions may resolve, but in some cases may be permanent.

Consent to Unforeseen Conditions: During treatment, unknown conditions may modify or change the original treatment plan, such as discovery of changed prognosis for adjacent structures or teeth. I therefore consent to such additional or alternative procedures as may be required in the best judgment of the treating dentist.

Compliance with Self-Care Instructions: I understand the necessity of maintaining good oral hygiene for better healing and that tobacco and alcohol products may negatively affect healing.

Patient's Endorsement: My endorsement (Signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied and that after thorough deliberation, I give my consent for the performance of any and all procedures related to the placement of dental implant(s) as presented to me during the consultation and treatment plan presentation by the dentist.

Signature of Responsible Party

Date

Patient's Name

Relationship to Party
(If Responsible Party is not Patient)

-OFFICE ONLY-

I confirm with my signature that I have discussed with the above named patient the risks, potential complications and intended benefits of the biopsy, as well as alternatives. The patient has had the opportunity to ask questions, all questions have been answered and the patients has expressed understanding, thus informed, the patient has requested that I perform a biopsy upon him/her.

Signature of Doctor

Date

Witness to Signature Only

Date