

BIOPSY CONSENT FORM

I, _____ authorize Dr. Stephen H. Christiansen and staff to perform the following procedure: _____

I agree to the administration of the anesthetic that I have chosen, which is:

- Local
- Local with oral pre-medication
- Local with nitrous oxide/oxygen analgesia
- General anesthesia

- _____ 1. I understand that there are known complications of surgery and the administration of drugs and anesthetics which include (but are not limited to) : pain and discomfort, swelling, bleeding, bruising, and infection. Lower jaw surgery may involve certain sensory nerves, resulting in temporary or permanent numbness of the lip, chin, teeth, cheeks, gums, or tongue. Changes in the bite or restricted mouth opening secondary to stress on the jaw joint (TMJ) may occur. There is also the possibility of injury to adjacent teeth or other tissues of the face, bone fractures, delayed healing, dry socket, and referred pain to the ear or head. With upper tooth extractions, an opening may occur between the sinus or nasal passage and the mouth, which may require further care.
- _____ 2. Anesthetic risks include: soreness, bruising, infection, and allergic reactions. When medications are placed in a vein, there may be inflammation at the injection site which may cause prolonged discomfort or disability and may require further care. There may also be nausea, vomiting, or other allergic reactions.
- _____ 3. Medications, drugs, anesthetics, and prescriptions may cause drowsiness, and lack of awareness or coordination which could be increased by the use of alcohol or other drugs. It is advisable not to operate any vehicle or hazardous devices, or to work while taking these medications. Recovery from such medications may take over 24 hours.
- _____ 4. I have had all my questions concerning this procedure answered to my satisfaction and I understand that there is no guarantee/warranty as to any result and/or cure. If unforeseen circumstances require additional procedures to those described above, I give permission for the exercise of professional judgment.
- _____ 5. I understand that no guarantee can be promised and I give my free and voluntary consent for treatment. I realize that my doctor may discover conditions requiring different surgery from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgment.

Due to the nature of oral lesions and their cancerous potential, your biopsy specimen is being sent to an oral pathology laboratory, where it will be carefully examined by a doctor who specializes in reading biopsies of the oral cavity. We do not want to compromise your care by sending it to a laboratory that does not deal specifically with oral lesions. We will send your insurance information, if any, to the laboratory with your specimen, but if your insurance company does not cover the cost, you will be responsible for it. We feel that this is in your best interest. _____ (Please Initial)

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved with the proposed surgery and anesthesia. I understand that I am responsible for any amount not covered by my insurance company. I certify that I understand, read, and write English.

Signature of Patient (or Legal Guardian) Date

Signature of Doctor Date

Signature of Witness Date