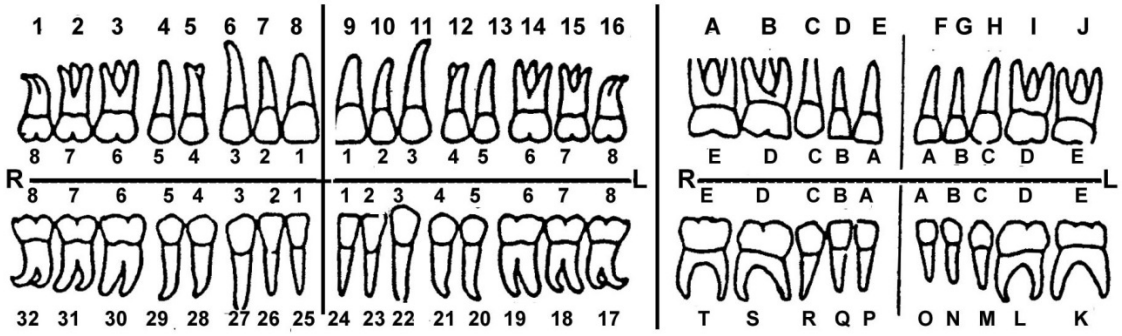
McBride Carr
Rick McBride, DDS
Brian Carr, DDS, MD

SAN BENITO ORAL and MAXILLOFACIAL SURGERY

A DENTAL PRACTICE

PERMIT FOR OPERATION

Name: _____



PROCEDURE: _____

This is my consent for the oral and maxillofacial surgery indicated on the examination cart and any other surgery deemed necessary or advisable as a corollary to the planned operation by R. L. McBride, D.D.S. or B. Carr, M.D, D.D.S. I have been informed of the available alternatives of treatment, the risks of non-treatment and the possible complications of the surgery, anesthesia and drugs. I understand that there are occasional complications in connection with oral and maxillofacial surgery such as:

___ swelling
___ discomfort
___ jaw muscle and joint stiffness
___ damage to and/or loss of other teeth
___ bleeding
___ infection
___ **numbness or tingling of the lip, chin, gum, teeth and tongue, which may be permanent**
___ bone fractures
___ sinus problem

I also agree to the use of local and/or general anesthetic, depending upon judgment of the doctor involved in my case. I realize a perfect result cannot be warranted. I certify that I have had an opportunity to fully read and understand the terms and words within the above consent to the operation and the explanation referred to or made, and all blanks, or statements requiring insertion or completion were filled in and in applicable paragraphs, if any, were stricken out before I signed. I also state that I speak, read, and write English. I understand that Dr. McBride or Dr. Carr may not be in this office every day, and I may have to see the other doctor for my post-operative appointment. Fees have been discussed and are satisfactory.

Signed: _____ **Date:** _____

Doctor: _____ Witness: _____