Consent Form for Orthognathic surgery

Dental Hospital

Patient Information

Name.....Age.....years HN. .....WARD.....

Schedule Procedure..... Date .....

I, ..., hereby consent to the treatment and/or surgical procedure performed by Dr. ..... and their medical team to address my condition or that of the person under my guardianship, using the following method(s): .....

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This procedure can be explained in simpler terms as follows:

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1. I have been thoroughly informed by the dental/ medical team about the benefits, risks, and procedural details of the treatment. Additionally, I have been informed about alternative treatment options that may be available for my condition, allowing me to make an informed decision. I fully understand that I have the right to refuse the proposed treatment.

2. Risk and possible complications.

2.1 **Pain** : Pain is a common occurrence; however, pain relief medication will be provided according to the level of discomfort experienced by the patient.

2.2 **Swelling**: Swelling is expected in all patients but can be alleviated with cold compresses in the initial stage. Swelling usually peaks within 24-48 hours post-surgery and then gradually improves. If no infection occurs, swelling should subside within four weeks. In most cases, anti-swelling medication will be administered intravenously before surgery and for 2-3 days after surgery.

2.3 **Numbness** : Temporary numbness in the lips and chin is a common complication of this type of surgery. The numbness gradually diminishes and typically resolves on its own. However, in approximately 1-2% of cases, permanent numbness may occur.

2.4 **Excessive bleeding** : As this is a bone surgery, significant blood loss may occur. If excessive blood loss is observed, a blood transfusion may be necessary to compensate for the lost blood or to address any abnormal bleeding conditions.

2.5 **Infection** : Although rare, infections can occur. Surgery performed in a standard operating room and in patients with normal immune function has a low risk of infection. However, if an infection does develop, it can be treated with antibiotics or, in some cases, drainage may be required.

2.6 **Bone misalignment or relapse** : Postoperative bone movement or temporomandibular joint displacement (relapse) may occur, leading to improper dental occlusion or facial asymmetry. In such cases, orthodontic treatment may be necessary, and in some cases, additional surgery may be required.

2.7 Other possible complications : .....

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3. I acknowledge and accept that the dental/ medical team cannot guarantee the outcome or the absence of risks, despite their utmost care and caution in performing the procedure.

4. The medical team may modify the treatment as necessary to achieve the best possible outcome. In the event of any failure or complications following the procedure, I agree to be responsible for any additional costs incurred.

5. Financial disclosure

The Operating Room Nurses and Benefits Unit Officers have informed me in detail about the treatment costs, including surgical fees, equipment and hospital charges, anesthesia costs, and any other necessary materials. Additionally, I have been informed about which expenses are covered by my medical benefits and which are not (in cases where I am eligible for medical benefits such as health insurance, government benefits, social security, local administrative organization benefits, etc.).

6. I fully understand and accept all the information stated above without any doubts and am prepared to undergo the procedure accordingly.

Signature:	Signature: .....
(.....)	(.....)
Treating Dentist	Patient / Authorized Representative
	Relationship to the patient: .....
Signature:	Signature: .....
(.....)	(..... .....)
Witness	Witness
	Date: ..... Time: .....

Note:

1. If the patient comes alone, please note “Patient came alone” in the witness signature field.
2. If the patient is under 18 years old, a parent or guardian must sign the patient/guardian field.