

Biopsy Consent Form

Patient Name: _____

Date: _____

If you have any questions, please ask your doctor BEFORE signing.

You have the right to be given pertinent information about your proposed surgery so that you may make an informed decision as to whether or not to proceed. A biopsy is a surgical procedure whereby a sample of tissue is taken for microscopic study to determine if it is normal.

In your case, the area of concern is

The plan is to:

Remove the suspected tissue totally. If the biopsy report is suspicious, it may be necessary to return to the area to remove additional tissues to obtain a margin of safety.

Remove only enough tissue to get a good sample, leaving the remaining tissue behind. (This is usually done when the lesion is large, it is suspected to be benign, or the removal of all of it at this time would be unnecessarily difficult.) However, if the biopsy report is suspicious, the entire lesion may have to be removed later.

1. I understand that a biopsy requires an incision(s) in my mouth or on the skin which will require stitches, and sometimes the removal of bone tissue. It has been explained that there are certain risks associated with the surgery, including (but not limited to):
 - a) Scarring.
 - b) Post-operative discomfort and swelling that may require several days of at-home recuperation.
 - c) Prolonged or heavy bleeding that may require additional treatment.
 - d) Post-operative infection that may require additional treatment.

- e) Stretching of the corners of the mouth that may cause cracking and bruising and which may heal slowly.
- f) Injury to nearby teeth or tissue, damage to dental appliances, and injury to salivary glands or ducts.
- g) Restricted mouth opening for several days. Sometimes related to swelling, muscle soreness and sometimes related to stress in jaw joints (TMJ).
- h) Reactions to medications, anesthetics, sutures, etc.
- i) Injury to sensory nerve branches in the area of the biopsy which may result in pain or a tingling or numb feeling in the lip, chin, tongue, cheek, gums or teeth, or in areas of the skin of the face. Usually, this disappears slowly over several weeks or months, but occasionally the effects may be permanent.
- j) If bone tissue is removed, healing may take longer, some complications may be more likely (for example, bleeding), and the biopsy report may take longer due to special processing requirements.
- k) Opening into the sinus (a normal bony chamber above the upper back teeth) requiring additional treatment.
- l) There is always a possibility of the lesion recurring in the same area, even when it appears to be totally removed.
- m) Other:

2. It has been explained to me that during the course of surgery unforeseen conditions may be revealed which may necessitate extension of the original procedure or a different procedure from that planned.

3. **Anesthesia:** The anesthetic I have chosen for my surgery is:

- Local Anesthesia
- Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
- Local Anesthesia with Intravenous Sedation

4. **Anesthetic Risks include:** In rare instances, patients can have a severe reaction to anesthesia, which may require emergency medical attention. Patients can also find that it can reduce their ability to control swallowing. This increases the chance of swallowing or aspirating foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver

to take me home. Temporary or permanent nerve injuries rarely result from an injection. There may also be inflammation at the site of intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Certain anesthesia risks also include but are not limited to unfavorable reactions to anesthetic drugs, nausea, vomiting, allergic reaction, and even cardiac arrest.

5. I understand that I may be given appointments for long-term follow-up care after my biopsy, even if the biopsy report is benign. I recognize the importance of returning for such follow-up(s). I agree to comply by regularly scheduling exams as instructed and to notify the office if I suspect a change in my condition.

6. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, alcohol and recreational drug use, and pregnancy (if applicable). I understand the necessity of maintaining good oral hygiene for better healing.

7. I have informed the dentist I am a:
 Non-smoker
 Smoker, and I have been counseled that tobacco products may negatively affect healing.

8. I understand that a sample of my tissue will be sent to an oral pathology laboratory for microscopic study.

Informed Consent: I have been given the opportunity to ask any questions regarding the nature and purpose of the surgical treatment and have received answers to my satisfaction. By signing this form, I am freely giving my consent to allow and authorize

to render the described treatment. I understand that no guarantee as to results (functional, aesthetic, or otherwise) can be or has been promised. I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent, and I fully understand the risks involved in the proposed surgery and anesthesia.

BEFORE SIGNING, PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT.

Patient (Or Legal Guardian) Signature:

Date: _____

Dentist Signature: _____

Date: _____

Witness Signature: _____

Date: _____