NORTH BETHESDA PERIODONTAL GROUP

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DIPLOMATES AMERICAN BOARD OF PERIODONTOLOGY

Biopsy Consent Form

Patient Name: _____ Date: _____

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

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 _____

It is planned 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. Post-operative discomfort and swelling that may require several days of at-home recuperation.
    b. Prolonged or heavy bleeding that may require additional treatment.
    c. Post-operative infection that may require additional treatment.
    d. Stretching of the corners of the mouth that may cause cracking and bruising and which may heal slowly.
    e. Restricted mouth opening for several days. Sometimes related to swelling, muscle soreness and sometimes related to stress in jaw joints (TMJ).
    f. Reactions to medications, anesthetics, sutures, etc.
    g. 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 disappear slowly over several weeks or months, but occasionally the effects may be permanent.
    h. 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.
    i. Opening into the sinus (a normal bony chamber above the upper back teeth) requiring additional treatment.
    j. There is always a possibility of the lesion recurring in the same area, even when it appears to be totally removed.
    k. 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. I authorize my doctor to perform such additional procedures as are necessary in the exercise of a professional judgment.
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
□ General Anesthesia

4. **Anesthetic Risks include**: discomfort, swelling, bruising, infection and allergic reactions. There may be inflammation at the site of intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting although considered safe, carries with it the risk of heart irregularities, heart attack, stroke, brain damage or death.

5. **Your obligations if IV anesthesia is used**
    a. Because anesthetic medications cause prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
    b. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
    c. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
    d. **However**, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, **using a small sip of water.**

6. 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 recognice the importance of returning for such follow-up

Informed Consent: As a patient, I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment and have received answers to my satisfaction. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize *Dr. Khalid Choudhary & Dr. Joan Howanitz* to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications**:** 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. I certify that I speak, read and write English.

PLEASE ASK THE DOCTOR OR ANY OF THE STAFF IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT.

Patient (Or Legal Guardian) Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Witness Signature: _____ Date: _____