

**CONSENT FOR GENIOPLASTY
(Surgery for Chin Repositioning)**

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Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

The surgery planned for you is designed to change the position/contour of your chin, and it is important that you understand the benefits and risks of such surgery. This is NOT minor surgery and you have the right to be fully informed about your condition and the recommended treatment plan. The disclosures in this consent are not meant to alarm you, but rather to provide information you need in order to give or withhold your consent to the planned surgery.

Patient's Name

Date

___ 1. Dr. _____ has described my condition as:

_____.

___ 2. The surgical procedure planned to treat the above condition has been explained to me, and I understand the nature of the treatment to be:

_____.

___ 3. I have been informed of possible alternative forms of treatment (if any), including:

_____.

4. My doctor has explained to me that there are certain potential risks and side effects of my planned surgery, some of which may be serious. They include, but are not limited to:

___ A. Facial swelling, usually lasting several days or longer.

___ B. Bleeding, both during and after surgery.

___ C. Bruising and discoloration of the skin and gum tissue around the lips, jaw, face and neck.

___ D. Allergic reaction to any of the medications given during or after surgery.

___ E. Delayed healing of the bony segments, possibly requiring a second surgery and/or bone graft to repair.

___ F. Relapse: the tendency for the repositioned bone segments to return to their original position, which may require additional treatment, including surgery and or bone grafting.

___ G. A change in cosmetic appearance, not every aspect of which can be exactly predicted. There may be decreased function of muscles of facial expression in the area of surgery.

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___ H. Loss of feeling, numbness, tingling or a painful sensation in chin, lips, gums and teeth. These symptoms occur in a significant number of patients and may last for several days, weeks, or months. In rare instances, some alteration of sensation may be permanent.

___ I. Scarring of the lining of the lip (mucosa), or of the skin.

___ J. Use of artificial “bone-substitute” materials to maintain or enhance facial contours, fragments of which may be lost through the incision, or may even require later removal.

___ K. Possible need for additional procedures to remove fixation devices such as pins, screws, plates or splints.

___ L. Some possibility of injury to the roots of lower front teeth, or interruption of their blood supply. That may require root canal procedures or could result in the loss of those teeth.

___ M. Post-operative infection that may cause loss of adjacent bone and/or teeth and may require additional treatment for a prolonged period of time.

___ N. Discomfort in the jaw joints (TMJ) resulting in some change in chewing difficulties or bite changes, usually of a temporary nature, but may be permanent.

___ O. Stretching of the corners of the mouth causing cracking with resulting discomfort and slow healing.

___ P. Inflammation of veins (phlebitis) that are used for IV fluids and medications, sometimes resulting in pain, swelling, discoloration and restriction of arm or hand movement for some time after surgery.

5. I realize the importance of providing true and accurate information about my health, especially concerning pregnancy, allergies, medications (including “natural” remedies and vitamin therapy) and history of drug, tobacco or alcohol use. If I misinform my doctor I understand the consequences may adversely affect the results of my surgery and could be life threatening.
6. I understand that oral hygiene will be difficult following surgery, but will do my utmost to follow normal tooth brushing and oral hygiene routines.

Consent:

By signing this consent form, I acknowledge that I have read it completely and understand the procedure to be performed as well as the risks associated with it. I am aware of the alternatives to this procedure, if any. I have had all my questions answered to my satisfaction. I was under no pressure to sign this form and have made a voluntary choice to proceed with surgery. I am fully aware that no guarantee or warranty can be made regarding the results of treatment.

Patient’s (or Legal Guardian’s) Signature Date

Doctor’s Signature Date

Witness’ Signature Date