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Biopsy Consent Form

Purpose of Biopsy:

I have been informed of the appearance of abnormal tissue in my mouth and that the proper evaluation of this tissue requires a biopsy. A biopsy involves the removal of a portion or all of the abnormal tissue so that it can be examined histologically (microscopically) to ascertain the nature of the abnormality and/or rule out the presence of serious disease.

Description of the Procedure:

- Remove the entire lesion (excisional)
 - o If the lesion is small, the entire lesion will be removed. If microscopic diagnosis is suspicious, it may be necessary to return to the area to remove additional tissues.
- Remove a portion of the lesion (incisional)
 - o This is usually done when the lesion is larger. However, if the biopsy report is suspicious, the entire lesion may have to be removed at a later time.

Risks Related to the Procedure:

Risks related to biopsy might include, but are not limited to:

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| <ul style="list-style-type: none">- Allergic reactions- Post surgical infection, bleeding, swelling, pain and/or bruising- Facial discoloration- Tooth sensitivity to heat, cold, sweets, acidic foods, etc.- Shrinkage of the gums upon healing which could lead to elongation of and/or greater spaces between some teeth | <ul style="list-style-type: none">- Nerve injury causing transient and occasional numbness or tingling of adjacent facial or jaw areas- Injury to the jaw joint and/or soreness of associated chewing muscles- Injury to adjacent teeth during surgery- Scarring or other cosmetic changes |
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Rarely there may be an opening into the sinus cavity which could require additional treatment. Certain lesions may intimately involve sensory nerves, injury to which may cause pain, tingling or numbness in the areas of the lips, chin, tongue, cheek, gums, teeth or areas of the skin of the face. Rarely, motor nerves may also be involved.

If bone tissue is removed, healing may take longer and some complications may be more likely (ie: bleeding). The biopsy report in these scenarios will take more time due to special processing requirements. There is always the possibility of the lesion recurring in the same area even when appearing to be completely removed.

Risks related to the anesthetics used during biopsy include:

- Allergic reactions
- Accidental swallowing of foreign matter
- Facial swelling, bruising, pain, soreness or discoloration at the site of injection

Any of the above may require additional medications or other care.

Alternatives to the Procedure:

1. No treatment and understanding that my condition may progress and adversely affect my health, particularly as it relates to potential malignancy.
2. Observation of the lesion over a specific time period. If this choice is selected, it is vitally important that frequent follow-up appointments are necessary.

No Warranty or Guarantee:

I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful. It is anticipated that the surgery will provide benefit in assessment of the abnormally appearing tissue; however, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, need for selective retreatment or worsening of my present condition despite the best of care.

Consent to Unforeseen Conditions:

During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include but are not limited to: extraction of hopeless teeth, removal of a root/root fragment/foreign body associated with the biopsy site, or termination of the procedure prior to completion of all of the surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

Compliance with Self-Care Instructions:

I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth and to the use of prescribed medications. I also 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 such a follow-up, which, if not done, may result in progression of my condition where additional care of surgery is required or the lesion may recur and become a threat to my health. I agree to comply with regular exams as instructed and to promptly notify this office if I suspect a change in my condition.

Records and Their Use:

I consent to photography, video recording and X-rays of my oral structures as related to these procedures and for their educational uses in lectures or publications provided that my identity is not revealed.

Patient Signature:

My signature to this form indicates that I have read and fully understand the terms used within this document and the explanations referred to or implied. After thorough consideration, I give my consent for the performance of any and all procedures related to biopsy as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

Patient Signature

Date

Guardian Signature (if patient is under 18)

Date