INFORMED CONSENT FOR TOOTH EXTRACTION(S)

I UNDERSTAND that treatment of TOOTH EXTRACTION(S) includes certain risks and possible unsuccessful results, with even the possibility of failure.

In order for me to make an informed decision about undergoing the procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives, and the consequences of not having it. The doctor has provided me with this information to my satisfaction.

The doctor has explained the nature of my condition to me: Disease of teeth

By signing this informed consent, I agree to assume those risks, possible unsuccessful results, and/or failure associated with, but not limited to, the following: (Even though care and diligence are exercised in the treatment of conditions requiring extraction(s), there are no promises or guarantees of anticipated results.)

1. **Dry socket**—This is jaw pain beginning a few days after surgery, usually requiring additional care. (This is more common from lower extraction, especially wisdom teeth, and in smokers.)

2. **Gum recession**—The procedure could possibly expose crown margins. The change tissue height is usually temporary. Uncommonly, these effects may persist.

3. **Sharp ridges or root tips**—These may form later at the edge of the socket, requiring surgery to smooth or remove them. Incomplete removal of tooth fragments may lead to injury of vital structures such as nerves or sinuses, and sometimes small root tips may be left in place for this reason.

4. **Sinus complications**—Roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus, or an opening may occur into the mouth that may require additional care.

5. **Complications from surgery**—These may include infection, loss of fillings, injury to other teeth or soft tissues, jaw fracture, sinus exposure, or swallowing or aspiration of objects used to perform the surgery.

6. **Alternate treatment options**—During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure or a different procedure altogether. I request that the doctor do the procedures the doctor thinks are better at this sitting rather than later on.

7. **Permanent or temporary numbness—**I understand that I will be given a local anesthetic injection and that in rare instances patients have had allergic reactions to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand the injection areas may be uncomfortable following treatment, and that my jaw may be stiff and sore from holding my mouth open during treatment.

8. **Patient acknowledges—**It is my responsibility to seek attention should any undue or unexpected problems occur and also to diligently follow any instructions, including the scheduling and attending of all appointments.

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the nature and purpose of extraction(s) treatment and have received answers to my satisfaction. I have been given the option of seeking endodontic therapy with a specialist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me.

The fee(s) and insurance contribution 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. _____ to render any treatment necessary and/or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient's name (please print): _____

Signature of patient or legal guardian: _____

Date: _____