The Dental Extraction Clinic

Consent for Extraction of Teeth

I, the undersigned, consent to the surgical extraction of teeth number(s):_____ using local anesthesia and any additional surgical procedures related to the extraction(s) that, in the professional judgment of the dentist, are deemed diagnostically or therapeutically necessary to increase the likelihood of success. I understand that the dentist performing the surgery is a general dentist who limits his practice to oral surgery, and I am declining referral to a surgical specialist. I understand that if any unexpected difficulties occur during treatment, the doctor may send me to an oral surgeon for additional treatment and I am responsible for the fees associated with that treatment.

I understand that extraction of teeth is an irreversible process and whether routine or difficult is a surgical procedure with risks that include but are not limited to:

Swelling and/or bruising and discomfort in the surgery area, stretching of the corners of the mouth resulting in cracking or bruising, possible infection requiring further treatment, dry socket (jaw pain beginning a few days after the surgery, usually requiring additional care, it is more common from lower extractions, especially wisdom teeth), possible damage to adjacent teeth especially those with large fillings or crowns, numbness or altered sensation in the teeth, lip, tongue, cheek, and/or chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or injured (sensation often returns to normal, but in rare cases, the loss may be permanent), trismus (limited jaw opening due to inflammation or swelling around the TMJ aka jaw joint), bleeding (significant bleeding is not common but persistent oozing can be expected for several hours), sharp ridges or bone splinters which may form later at the edge of the socket (these may require another minor surgery to smooth or remove them), incomplete removal of tooth fragments (to avoid injury to vital structures such as nerves or sinuses, sometimes small root tips may be left in place), sinus involvement (the roots of upper back teeth are often close to the air filled space called the maxillary sinus. Sometimes a piece of root can be displaced into the sinus, or an opening into the mouth may occur which may require additional care), jaw fracture (while quite rare, it is possible in difficult or deeply impacted teeth) and allergic reactions to medications or anesthetics that may be used.

- I have been informed that risks to my health if this procedure is not performed may include but are not limited to: continued or increased pain and/or infection, loss of bone around adjacent teeth causing their loss, and increased risk of complications if surgery is postponed.
- I acknowledge that if alternative methods of treatment are available, they have been discussed with me.

The potential benefits include but are not limited to: treatment of pain and/or infection and/or the ability to proceed with proposed treatment.

By signing below, I attest that I have read, understand and agree to the above, and have had all of my questions answered to my satisfaction. I have discussed any alternatives to the extraction(s) with my dentist including the risks and benefits. I agree to diligently follow any postoperative instructions given to me and report any unanticipated reactions to the office as soon as possible.

_____ _____

Patient's or Guardian's Signature **Date**

_____ _____

Witness Signature **Date**