CONSENT FORM FOR TOOTH EXTRACTIONS AND RELATED SURGERY

We would like our patients to be informed about the various procedures involved in tooth extraction and have their consent before starting treatment. Tooth extraction is performed to completely remove a primary or permanent tooth or teeth, which cannot be maintained or restored. An extraction can be surgical or non-surgical. This depends on the difficulty of the extraction and whether or not the tooth is erupted or impacted, and whether it has straight or curved roots. The following discusses possible risks that may occur from oral surgery treatment, and other treatment choices.

My dentist has recommended the following tooth (teeth) be extracted: _____

This recommendation is based on visual examination(s), on any radiographs, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and wants have also been taken into consideration. The extraction(s) is necessary because of:

☐ Pain ☐ Infection ☐ Periodontal (gum) disease ☐ Decay ☐ Non-Restorable teeth
☐ Patient declines RCT ☐ Other _____

The intended benefit of extraction/oral surgery is to relieve my current symptoms and/or permit me to continue with any additional treatment my dentist has proposed. I have been advised that extraction of my teeth can cause malocclusion (bite problems) if the tooth is not restored or replaced in a timely fashion. ☐

GENERAL RISKS

I have been informed of the risks and complications of the recommended oral surgical procedures, anesthesia, and the proposed drugs including (but not limited to): pain; infection; edema (swelling); heavy life-threatening or prolonged bleeding; ecchymosis (bruising); hematoma; face and neck discoloration; nerve injury - particularly with wisdom teeth extractions resulting in numbness, pain and tingling of the lip, tongue, chin, gums, cheeks and teeth which may be transient (temporary) but on infrequent occasions may be permanent; temporary or permanent taste alterations; numbness and phlebitis (inflammation of a vein) from an intravenous and/or intermuscular injection; injury to and stiffening of the neck and facial muscles; malfunction of the adjacent facial muscles for an indefinite time; change in occlusion or temporomandibular (jaw) joint difficulty; or injury to adjacent teeth or restorations in other teeth; or injury to adjacent soft tissue.

I have further been informed of other potential complications including, (but not limited to) nausea; vomiting; allergic reactions; bone fractures; bruises; delayed healing; sinus complications - openings from the sinus into the mouth; apparent facial changes; nasal changes; the possibility of secondary surgical procedures; loss of bone and the invested teeth; non-healing of the bony segments; devitalization (nerve damage which may require a root canal) of teeth and relapse; recession (shrinkage) of the gingival tissue.

I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of this procedure, the associated treatment and procedures, or the post-surgical dental procedures. I am further aware that there is a risk of failure and/or further corrective surgery may be necessary. Such a failure and remedial procedures may involve additional fees being assessed.

If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated, I further authorize and direct Dr. _____, his/her associates or assistants of his/her choice, to do whatever he/she/they deem necessary and advisable under the circumstances, including the decision not to proceed with the surgical procedure.
I understand that certain situations/problems may arise from dental surgeries that require referral to a medical/dental specialist for completion or treatment. The specialist will evaluate the problem and recommended additional procedures which will involve additional fees being assessed. ☐

MEDICATIONS

I authorize Dr._____ to perform the recommended dental procedures. I agree to the type of anesthesia that he/she has discussed with me, specifically local anesthetic or any combination deemed necessary and advisable under the circumstances. I agree not to operate a motor vehicle or hazardous device for at least twenty-four (24) hours after the procedure or until fully recovered from the effects of the anesthesia or drugs given for my case.
In some instances, the dentist will prescribe antibiotics to treat infection. In the event you are prescribed antibiotics and you are female, your current contraceptive (birth control) methods may become less effective to that end; to decrease the risk of becoming pregnant it is essential that you use an additional method of contraception. ☐

POST-OPERATIVE CARE AGREEMENT

I agree to cooperate with the post-operative instructions of my dentist, realizing that any deviation from the instructions or lack of cooperation could result in less than optimum results. I further agree that if I do not follow my dentist's recommendations and advice for post-operative care, my dentist may terminate the dentist-patient relationship, requiring me to seek treatment from another dentist. ☐

OTHER TREATMENT CHOICES

These include no treatment, waiting for more definite development of symptoms, or if possible root canal therapy to save an otherwise hopeless tooth. Risk involved in these choices might include pain, infection, swelling, loss of teeth, infection to other areas, and worsening of my present condition. ☐

QUESTIONS

_____
_____
_____
_____
_____

CONSENT

To my knowledge, I have given an accurate report of my health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other condition relating to my health or any problems experienced with any medical, dental or other health care and treatment.

The fee for services has been explained to me and is acceptable, and I understand that there is no warranty or guarantee as to the result of this treatment. The fee for an uncomplicated extraction is $_____.
If the extraction is complicated (surgical) the fee is approximately $_____.

I realize and understand that the purpose of this document is to evidence the fact that I am knowingly voluntarily consenting to the oral surgical procedures recommended by my dentist. The risks, benefits, and alternatives for treatment have been explained and I accept the proposed oral surgical procedure(s) recommended by my dentist.

"I certify that I have read and fully understand the above authorization and informed consent. I give my consent willingly to this procedure. All my questions have been answered to my complete satisfaction and I have been given ample time to understand this consent. I also certify that I read and write English."

Patient/Parent/Guardian Date Witness