



Informed Consent for Dental Extraction

Dr. _____ has explained the benefits and risk of tooth removal to me. I understand that surgical extraction may be necessary. Referral to a specialist (oral surgeon) has been offered.

I understand and accept the treatment recommended for me by Dr. _____. I further understand that there may be some unwanted complications, some of which are listed below. No guarantees have been made or implied. Dr. _____ has discussed whether or not the tooth/teeth he has proposed be extracted are impacted to any degree. I understand that an impacted tooth may have begun to erupt in the wrong direction and may be blocked fully from erupting by bone and adjacent teeth. I understand that allowing impacted teeth to remain may result in infection and/or cyst formation which may destroy bone: damage the roots of adjacent teeth from pressure of the malposed tooth/teeth; and/or create a food trap which may result in decay. Alternative treatment(s) or the option of no treatment has been explained to me. I understand the risk of not having the extraction(s) performed, whether the tooth/teeth are impacted, partially impacted, or not impacted at all, include, but are not limited to: infection, swelling, pain, periodontal disease, malocclusion, and systemic disease. All of my questions have been addressed.

Proposed fees have been explained to me, as have any third party insurance benefits. I understand that third party benefits may be different than discussed by Dr. _____ as they are not under the control of this office.

Treatment risk/unwanted consequences may be (but are not limited to):

- Reaction to medications/anesthetic.
- Temporary or permanent numbness or tingling of the lip, chin, tongue or other areas.
- Post treatment bleeding.
- Post treatment infection.
- Post treatment tissue swelling.
- Root fragments may break: they may be left in the jaw.
- Sinus involvement when upper teeth are removed, which may require additional treatment.
Jaw or alveolar bone may fracture during tooth removal, which may require additional treatment.
- Healing may be delayed and require additional treatment such as for a dry socket.
- Sensitivity, pain.
- Damage to adjacent teeth or restorations.

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Patient Signature _____ Date _____

Witness _____ Date _____