

INFORMED CONSENT FOR TOOTH REMOVAL EXTRACTION

Dr. _____ has explained to me the benefits and risks of tooth removal. I understand that surgical extraction may be necessary.

I understand and accept the treatment recommended for me. I further understand the possibility that complications may occur, some of which are listed below. No guarantees have been made or implied. I understand that an impacted tooth may have begun to erupt in the wrong direction any may be blocked from fully erupting by bone and adjacent teeth. I understand that allowing impacted teeth to remain may result in an 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 risks of not having the extraction(s) performed, whether the tooth/teeth are impacted, partially impacted or not impacted as 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, as they are not under the control of this office.

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

- * Reaction to medication/anesthetic
- * **Temporary** or **permanent numbness** or tingling of the lip, chin, face, tongue and gums
- * 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 treatment for a dry socket)
- * Sensitivity, pain
- * Damage to adjacent teeth or restorations

I read and understand the above information and the information verbally given to me concerning implant treatment. By my signature (below) I consent to the treatment described in this paper.

Date: _____

Patient's Signature: _____

Witness Signature: _____

Witness Name (printed): _____

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