Informed Consent Extraction

1. I have been informed and afforded the time to fully understand the purpose and the nature of the extraction surgery procedure. I understand what is necessary to accomplish the extraction(s).
2. After careful oral examination, a review of radiographs and study of dental condition, my doctor has advised me that I require an extraction because of advance bone loss, non restorable caries, tooth fracture, continuing infection, non-restorability, irreversible damage to the nerve tissue inside the tooth, failed endodontic therapy, or orthodontic needs. Extraction involves the complete removal of a tooth from the mouth. Some extractions require a small incision and sectioning the tooth into smaller pieces prior to removal. The intended benefit of this treatment is to relieve my current symptoms and/or permit further planned treatment.
3. I have been informed of the following possible alternative treatments, and the costs, risks, & benefits of each: no treatment, root canal therapy, filling, a crown, and/or gum treatment. I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure, including extractions.
4. I understand that during and following treatment I may experience pain or discomfort, bleeding, swelling, bruising, and stiff jaws, all of which may last for several days. Complications are extremely rare but may include infection, dry socket (loss of clot) loss of fillings, injury to other teeth or soft tissues, fractured (jaw, roots, bone fragments, or instruments), sinus exposure, bacterial endocarditis or swallowing or aspiration of debris.
5. I understand that during surgery injury to the nerves in my jaw that control sensations and function in my lips, tongue, chin, teeth, and mouth may occur but are very rare. This may result in temporary loss of sensation to the gum, lip or tongue, or in extremely rare cases, permanent numbness. Itching, burning, or tingling of the lip and tongue may also occur. I understand that I will be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or injury to the nerves or blood vessels from the injection.
6. I have provided complete and accurate medical and personal history, including current medication, prescription and non-prescription, which I take, and any known drug/food allergies. I will follow all instructions as explained and directed to me, and I will permit recommended diagnostic procedures, including X-rays. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure. I have been given the opportunity to ask questions regarding the benefit, risks, and alternatives of the procedure and have received satisfactory answers to all my questions.
7. I understand that drugs such as (Fosamax, Fosamax Plus D, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa and Bonefos) prescribed to decrease resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any oral surgical procedure involving bone, including extractions.
8. It is my responsibility to contact the dentist and seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given me. I understand that post extraction follow-up may be required for suture removal, extraction site care or debridement.
9. I am giving consent to allow the doctor to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.
10. Tooth #(s) to be extracted_____

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

Signature of Witness **Date**

_____ _____

Signature of Doctor **Date**