Extraction Consent Form

You have the right to be informed about your condition and the recommended treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to provide information so that you may give or withhold your consent.

I understand that these other forms of treatment or no treatment at all, are choices that I have and the risks of those choices have been presented to me.

My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment and in this specific instance they include, but are not limited to:
Post-operative discomfort and swelling that may require several days of at-home recovery.
Prolonged or heavy bleeding that may require additional treatment.
Injury or damage to adjacent teeth or fillings.
Post-operative infection that may require additional treatment.
Stretching of the corners of the mouth that may cause cracking or bruising, and may heal slowly.
Restricted mouth opening during healing; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.
A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
Fracture of the jaw (usually only in more complicated extractions or surgery).
Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums or tongue (including possible loss of taste sensation) and which may persist for several weeks, months or, in rare instances, permanently.
Opening of the sinus (a normal chamber situated above the upper teeth) requiring additional surgery or treatment.
Dry socket (loss of blood clot from extraction site). Allergic reactions (previously unknown) to any medications used in treatment.

It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

I have read and fully understand this consent for surgery, have had my questions answered and that all blanks were filled in prior to my initials or signature.

INFORMATION FOR FEMALE PATIENTS: I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my

treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.