Informed consent and permission form for EXTRACTIONS

Before you give your permission for the removal of teeth, removal of impacted teeth (those that are "buried" or beneath the gums) other dental treatment, or the administration of certain anesthetics, you should understand that there are certain associated risks.

We will be extracting teeth #(s) _____

Common risks include but are not limited to:

1. Drug reactions and side effects
2. Damage to adjacent teeth or fillings
3. Postoperative infection
4. Postoperative bleeding that may require treatment
5. Possibility of a small fragment of root being left in the jaw, and its removal, requiring extensive surgery
6. Delayed healing (dry socket) necessitating frequent postoperative care
7. Possible involvement of the sinus during removal of upper molars, which may require additional treatment or surgical repair at a later date
8. Possible involvement of the nerve, including but not limited to the removal of lower molars, resulting in temporary or possible permanent tingling or numbness, or pain of the lower lip, chin or tongue on the operated side
9. Bruising and/or vein inflammation at the site of administration of intravenous medications, which may require further treatment
10. In rare circumstances, breakage of the jaw
11. As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues, that is usually temporary. In rare instances, such numbness may be permanent.
12. Other_____
    _____

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I was given the option of different anesthetic techniques, and I consent for the following anesthetics to be used:

_____ Local anesthesia (injection)
_____ Local anesthesia (injection) with intravenous sedation
_____ Local anesthesia (injection) with oral premedication (pills before treatment)
_____ General anesthesia/hospital operating room

I hereby acknowledge that I have completely read the foregoing, have discussed any questions or concerns that I may have regarding my
proposed surgery/dental treatment, and have been given satisfactory answer. I am aware that the practice of dentistry is an inexact science and that no guarantees can be provided and none have been made to me.

Patient signature/legally authorized representative ***Date***

Printed name if signed on behalf of the patient ***Relationship***

Doctor signature ***Date***

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