Periodontics and Dental Implants

An explanation of your need for tooth removal was discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

Consent for Tooth Removal

DIAGNOSIS: I have been informed of the need for dental extraction (the removal of a tooth or several teeth). The reasons for this extraction have been explained to me.

SUGGESTED TREATMENT: It has been suggested that the tooth/teeth circled below be removed:

Upper Right																Upper Left
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
Lower Right																Lower Left

DESCRIPTION OF THE PROCEDURE: After anesthetic have numbed the area to be operated extraction will be accomplished by either the removal of the tooth/teeth or by surgical reflection of the gum, possible removal of some bone around the tooth/teeth, and possible sectioning of tooth roots to facilitate removal of the tooth/teeth. After the extraction, tooth socket(s) (hole in jawbone left by tooth removal) will be inspected, possibly cleansed of debris or infected soft tissue and when infected soft tissue may be submitted for histological examination to determine if pathology was present. Finally, the gum and socket or gum tissue may be sutured and measures will be taken to reduce bleeding from extraction area(s) after this procedure.

RISK RELATED TO THE SUGGESTED TREATMENT: Risks related to tooth removal surgery might include, but are not limited to, post-surgical infection, bleeding, swelling, pain, infection, facial discoloration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasms, fracture of the tooth/teeth during the surgery, retention of part of the root or roots, perforation of the upper jaw into the sinus, dislodging of a tooth or part of a tooth into the upper jaw sinus, swallowing of a tooth or fragments of a tooth, sensitivity to hot or cold or sweets or acidic foods, or shrinkage of gum upon healing. Risks related to the anesthetic might include but are not limited to allergic reactions, accidental swallowing/aspiration of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of injection of the anesthetic.

ALTERNATIVEES TO THE SUGGESTED TREATMENT MAY INCLUDE:

- No treatment, with the expectation of the advancement of my condition resulting in the greater risks or complications including, but not limited to, bone loss, pain, infection, and possible damage to the support of adjacent teeth.
- Root Canal treatment, with the expectation that this may not eliminate infection in the area, or that it may still lose the tooth in the near future.
- Restoration (filling or cap) of these tooth/teeth with the expectation that it/they may be lost in the near future.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that o guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in eradicating all pre-extractions symptoms or complaints. It is anticipated that the surgery will provide benefit in reducing the problems associated with these tooth/teeth. However, dude to the individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition including possible loss of certain teeth with advanced involvement, despite best care.

CONSENT TO INFORESEEN CONDITIONS: During surgery, unforeseen conditions could be discovered which would call for modification or change of the anticipated surgical plan. These may include but not limited to, extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or termination of the procedure as may be deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and the doctor can evaluate and report on the outcome of surgery upon completion of healing.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filing, recording and e-rays of my oral structure as related to these procedures and for their educational use in lecture or publications provided my identity is not revealed.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to tooth extraction as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

______________________________ ________ ______________________________
Patient's Signature Date Patient's Name

______________________________ ________ ______________________________
Signature of the Patient's Guardian Date Relationship to Patient

______________________________ ________
Signature of Witness Date