

Informed consent for Extractions

Diagnosis: After a careful oral examination, radiographic evaluation and study of my dental condition, the dentist has advised me that I may have one or all of the following gross caries (*commonly called cavities*), gingivitis/periodontitis, tooth fracture, infection and/or an abscess, malocclusion or malposition of the tooth/or teeth which is preventing the restoration of some other dentition.

Recommended Treatment: The dentist has recommended that a tooth or several teeth be extracted (*pulled*). I understand that oral sedation may be utilized and that local anesthetic (*commonly called Novocain*) will be administered as part of the surgery.

I understand that the purpose of this procedure/surgery is to treat and correct my disease. I have been advised if the condition persists without treatment/surgery, my present condition will probably worsen with time, and the risks to my health may include but are not limited to pain, swelling, infection, cyst formation, periodontal (*gum*) disease, dental decay, malocclusion, pathologic fracture of jaw, premature loss of teeth, and/or premature loss of bone.

Expected Benefits: The purpose of this surgery is to remove the infected tooth/teeth to eliminate the infection and avoid the problems listed above, and/or to relieve the pain and/or facial swelling I am currently experiencing.

Principal Risks and Complications: Sometimes complications may result from the extraction(s), or from anesthetics or drugs. There are certain inherent risks in any treatment plan or procedure, and in this specific instance such operative risks include but are not limited to, post-operative discomfort and swelling for one or several days or weeks, heavy bleeding, injury to adjacent tissue, teeth, fillings, caps or other dental work, post-operative infection requiring additional treatment, stretching, cracking or bruising of the corners of the mouth, restricted mouth opening for several days or weeks, decision to leave a small piece of root in the jaw when its removal would require extensive surgery, bony chips/fragments that may require removal at a later time, breakage of the jaw, injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth, and or tongue on operated side for several weeks, months and on rare occasion permanently, opening of the sinus requiring additional surgery, future orthodontic treatment of one or all of my teeth, mal-union, fibrous-union, and/or non-union of fracture sites, and a need for additional surgeries/procedures, and dry socket.

Alternatives to Suggested Treatment: Alternatives to periodontal dental extraction(s) include:

1. No treatment

Necessary Follow-up Care and Self-Care: I understand that it is important for me to continue to see my regular dentist for routine dental care and get the missing tooth/teeth replaced as recommended.

Smoking may adversely affect the extraction site healing and may cause a dry socket (*extremely painful for about one week*). Smokers have more dry sockets than non-smokers. I cannot use a water-pik in that area for three months. I have told the dentist about any pertinent medical conditions I have, allergies (*especially to medications or sulfites*) or medications I am taking, including over the counter medications such as aspirin. If a dry socket occurs, I understand I will need to come back so the dentist may treat the condition immediately. I know it is important to:

1. Abide by the specific prescriptions and instructions given
2. See the dentist for post-operative visits as needed





3. Not smoke or use smokeless tobacco for two weeks
4. Avoid water-piks as mentioned above until the site is healed
5. Have any non-dissolvable sutures (*stitches*) removed
6. Get the tooth/teeth replaced as recommended

No Warranty or Guarantee: While in most cases tooth/teeth extraction(s) heal quickly and without any problems, complications such as those listed previously, can happen despite the best of care.

Publication of Records: I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either advancement of dentistry or in promotional materials. My identity will not be revealed to the general public.

I further consent to the examination, testing and/or disposal of any parts or tissue which may be removed, in such a manner as may be determined by the dentist.

Communication with my Insurance Company, My Dentist or other Dental/Medical Providers involved with my care: I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion with my insurance carriers, dentist's billing agency, my dentist, and any other health care provider I may have who may have a need to know about my dental treatment.

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (*birth control pills*). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

Administration of local anesthetic: Medications, drugs and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased with the use of alcohol, or other drugs; thus I have been advised not to work or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs, or until fully recovered from the effects of the same.

Tooth to be extracted:

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling the Dentist of any pertinent medical conditions and prescriptions and non-prescription medications I am taking. I have had an opportunity to ask questions. I consent to the performance of the oral surgery as presented to me during my consultation and as described above. I also consent the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the Dentist. I have read and understand this document before I signed it.

Signature of patient or guardian

Printed Name

Date

Signature of Dentist

Printed Name

Date

