

Consent Form

Patient's name:

Patient's file #:

Treatment description: Dental extraction for: #

I hereby authorize and direct my dentist to perform surgical tooth extraction (or upon any person identified below as the patient, for whom I am empowered to consent).

I understand that it may be necessary to place sterilized synthetic bone matrix to help augment the extraction socket for future dental implants, bridges, or dentures. Extraction of teeth is an irreversible process and whether routine or difficult is a surgical procedure. We will do everything we can to make sure your treatment is problem-free. As in any surgery, there are some risks.

These risks include but are not limited to:

- Swelling and or bruising and discomfort in the surgical area.
- Possible infection requiring further treatment.
- Dry socket – jaw pain beginning a few days after surgery, usually requiring additional care, it is more common from lower extractions, especially wisdom teeth.
- Possible damage to adjacent teeth, especially those with large fillings or caps.
- The lower back teeth are adjacent to a large nerve. Numbness or altered sensation in the teeth, lip, tongue, and chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or injured. Sensation most often returns to normal, but in rare cases, the loss may be permanent.
- Trismus – limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes it is the result of jaw joint discomfort (TMJ), especially when TMJ disease and symptoms already exist.
- Bleeding – significant bleeding is not common, but persistent oozing can be expected for several hours.
- Incomplete removal of tooth fragments – to avoid injury to vital structures such
- as nerves or sinuses, sometimes small root tips may be left in place.

I fully understand the nature of this treatment as well as the difficulties related to it. I understand that it is always possible that one of the above cited complications occurs. I also understand that I will have to follow the post-op instructions given after the treatment.

Patient's signature: _____

Date: _____