SUBMIT

RESET

SAVE

NORTHPOINTE
FAMILY DENTISTRY

CONSENT FOR EXTRACTION(S)

I, _____, hereby authorize and request that Dr. _____ to perform the following extractions on teeth/tooth number(s) _____.

I am aware that an extraction involves the surgical removal of the tooth structure and root system of that tooth and surrounding bone and tissue. The extraction will be done either surgically, by sectioning the tooth, or by a simple extraction, by elevating the tooth out of its socket. The instruments that will be used will depend upon the nature and extent of the extraction. After the tooth is extracted, I also understand that sutures may be utilized.

I am aware that there are possible risks and complications from the surgical extraction of teeth which include but not limited to the following:

- Pain, bleeding, and swelling.
- Discoloration and bruising.
- Infection (requiring additional procedures or antibiotics).
- Numbness, altered sensation, tingling sensation to the lip, chin, cheeks, gums, teeth and tongue (which may be permanent).
- Changes in bite, chewing, eating, and speaking.
- MPD (jaw muscle pain) and TMJ (jaw joint pain and injury to the joints); dislocation of the jaw joint.
- Dry socket; inadequate clot formation; prolonged healing; requiring medicated packing.
- Allergic reaction and/or rashes from prescriptions
- Sinus hole, sinus perforation, and/or sinus involvement necessitating further surgery.
- Fractured root tip and/or fractured root, formation of bony splinters. (m) Residual root/tooth structure being left behind requiring another procedure.
- Phlebitis (inflammation of blood vessels).
- Injury to and stiffening of the neck and facial muscles.
- Lacerations, abrasions, scars, and retraction marks.
- Referred pain and injury to the ear, neck, and head.
- Injury or damage of other teeth and/or dental restorations including but not limited to fillings, crowns, and bridges.
- Injury to the gum tissues and surrounding bone in the jaw.

I understand that, should any of the complications written above occur, that I may require further and other surgical procedures. Should the dentist encounter an emergency situation, during any complication during the extraction of any of my teeth, I hereby authorize him/her with my consent to perform such surgical procedures as he deems necessary.

I know that the doctor does not guarantee the success of the treatment that he performs upon me. I know that there are known and accepted complications from surgical procedures that can occur even when the dentist has acted reasonably and properly. I hereby authorize him to undertake my treatment knowing these potential risks.

The dentist has explained to me all possible alternative treatments besides extraction. He has explained to me that my alternatives may include:

- ☐ No alternative due to hopeless prognosis for tooth/teeth
- ☐ Leaving the tooth in
- ☐ Root canal
- ☐ Post and Core
- ☐ Crown
- ☐ Filling
- ☐ other_____.

He has also explained to me the risks with respect to each and every one of these alternatives and I hereby reject those alternative treatments and request that he perform the extraction(s).

I understand that once the tooth is removed, there will be a space remaining that may or may not require replacement. Replacement options for my dental situation include;

☐ Implants ☐ Bridge ☐ Denture ☐ No replacement required

The following conditions are a possibility as a result of not replacing teeth, but not limited to; drifting of teeth, tipping of teeth, over eruption of opposing teeth, malocclusion, periodontal pocketing and bone loss.

I hereby acknowledge that Dr. _____has explained to me both through my reading of this informed consent form and also that he has verbally explained to me in detail the surgery, risks involved, alternative treatments, and the risks attendant to those alternatives. I hereby authorize him to operate.

_____ _____

Patients/Guardian signature Date

_____ _____

Dentist Signature Date