Tooth Extraction Consent Form

After careful oral examination, a review of radiographs and study of dental condition, The dentist has advised me that I require an extraction because of advanced bone loss, non restorable caries, tooth fracture, continuing infection, non-restorability, or orthodontic needs. Extraction involves the complete removal of a tooth from the mouth. Some extractions require elevating the gum tissue and exposing/removing bone and/or sectioning the tooth into smaller pieces prior to removal. The intended benefit of this treatment is to relieve my current symptoms and/or permit further planned treatment. I have been informed of the following possible alternative treatments, and the costs risks & benefits of each: no treatment, root canal therapy, filling, a crown, or gum treatment.

I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure, including extractions. I understand that during and following treatment I may experience pain or discomfort, bleeding, swelling, bruising, and stiff jaws, all of which may last for several days. Complications are extremely rare but may include infection, dry socket, loss of fillings, injury to other teeth or soft tissues, jaw fracture, sinus exposure, or swallowing or aspiration of debris.

I understand that during surgery injury to nerves in my jaw that control sensations and function in my lips, tongue, chin, teeth, and mouth may occur but are very rare. This may result in nerve disturbances such as temporary loss of sensation to the gum, lip or tongue, or in extremely rare cases, permanent numbness. Itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues may also occur. I understand that I will be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection.

I have provided complete and accurate medical and personal history, including current medications, prescription and non-prescription, which I take, and any known drug allergies. I will follow all instructions as explained and directed to me, and will permit recommended diagnostic procedures, including X-rays. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure. I have been given the opportunity to ask questions regarding the benefit, risks, and alternatives of the procedure and have received satisfactory answers to all my questions.

Print Name_____ Date: _____

Patient Signature _____Date: _____

Witness Signature _____ Date: _____

Tooth #'s to be extracted _____