Discussion and Consent for Extraction

Patient's Name:_____ Date of Birth:_____
Last *First* *Initial*

I am being provided with this information and consent form so that I may better understand the treatment recommended for me. Before making a treatment decision, I wish to be provided with sufficient information, in a way I can understand, in order to make a well informed decision regarding my proposed treatment.

I understand that I may **ask any questions I wish,** and that it is better to ask them before treatment begins than to wonder about it after treatment has started.

Nature of Extraction

It has been recommended that I have the following tooth (teeth) extracted:_____

Extraction involves the complete removal of a tooth from the mouth. Some extractions may require cutting into the gums and removing supporting bone and/or cutting the tooth into sections prior to removal.

This recommendation is based on visual examination(s), on any X-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and desires have also been taken into consideration. The extraction is necessary because of:

☐ Pain ☐ Infection ☐ Periodontal (gum) disease ☐ Decay ☐ Broken Tooth/Teeth ☐ Tooth is not restorable
☐ Other:_____

The intended benefit of extraction is to relieve my current symptoms and/or to permit me to continue with any additional treatment my dentist has proposed.

The prognosis, or likelihood of success, of this extraction is _____.

My extraction(s) is(are) estimated to cost $_____ and is estimated to take _____ visit(s) to complete.

Alternatives to Extraction

Depending on my diagnosis, there may or may not be an alternative to extraction that involves other types of dental care.

☐ Tooth #_____ can be restored/retained by:
☐ Root canal therapy ☐ Filling ☐ Crown ☐ Gum treatment, or ☐ Other treatment (specify):_____.

☐ Tooth #_____ cannot be restored. Extraction is the only reasonable treatment option.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including _____.
Patient's Initials

continued…

Risks of Extraction

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. I understand that it is possible for an infection to occur in the extraction site and that I may need antibiotics and/or other procedures to treat the infection. I understand that less common complications include: dry socket (lost blood clot); loss or loosening of dental restorations; loss or injury to adjacent teeth and soft tissues; jaw fractures; sinus exposure (upper teeth); swallowing or aspiration of teeth and restorations.

I understand that small root fragments may break off from the tooth being extracted. Depending on their size and position, they may either be left to remain in the jaw or may require additional surgery for removal.

I understand that during surgery it may be impossible to avoid touching, moving, stretching, or injuring the nerves in my jaw that control sensations and function in my lips, tongue, chin, teeth, and mouth. This may result in nerve disturbances such as temporary or permanent pain or numbness, and/or unusual sensations such as itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

I understand that extracting the tooth may not relieve my symptoms and that complications may occur. Other treatment or procedures may be necessary.

I understand that I may be given a topical anesthetic and/or local anesthetic injection. Although rare, it is possible that patients may have an allergic reaction to these medications. Adverse reactions to anesthetic medications are possible, such as lightheadedness, dizziness or drowsiness. Please contact Dr. _____ if numbness remains more than a few hours or if you develop a rash. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from the anesthetic injection. I also understand that temporary or permanent injury to nerves and/or blood vessels from the injection may occur. Nerve disturbances may include pain or numbness, and/or unusual sensations such as itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

Other foreseeable risks not stated above include:_____

_____ I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about, including _____.

Patient's Initials

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Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including medications I am currently taking (antibiotics, pain drugs, or other medications, including non-prescription medicines, herbs or supplements) and materials or medicines to which I am allergic. I will follow any and all treatment and post-treatment instructions as directed and explained to me and will permit the recommended diagnostic procedures, including X-rays.

I realize that in spite of the possible complications and risks, my recommended extraction/surgery/treatment is necessary. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the operation or procedure.

I, _____, have received information about the proposed treatment. I have discussed my treatment with Dr. _____ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risks of refusing treatment.

I wish to proceed with the recommended treatment.

_____ I understand this treatment can also be performed by an oral surgeon (a dental specialist). I understand the risks associated with this treatment and elect to have this procedure performed by Dr. _____. I understand that if any unexpected difficulties occur during treatment, I may be referred to an oral surgeon for further care.

Patient's Initials

Signed:_____ Date:_____

Patient or Guardian

Signed:_____ Date:_____

Treating Dentist

Signed:_____ Date:_____

Witness