EXTRACTION CONSENT FORM

PROPOSED TREATMENT: An extraction involves removing one or more teeth. Depending on their condition, this may require sectioning the tooth and removing some gum and bone tissue. If any unexpected difficulties occur during treatment, in may send you to an oral surgeon, a dentist who specializes in extracting teeth and performing other surgical procedures.

BENEFITS AND ALTERNATIVES: The proposed treatment will help to relieve your symptoms and may also enable you to proceed with further proposed treatment. There is no reasonable alternative treatment that will relieve your symptoms.

COMMON RISK:

- Bleeding, swelling, discomfort, and infection
- Reaction to anesthesia and/or sedation
- Stiff or sore jaw joint
- Dry socket
- Damage to adjacent teeth
- Opening into sinuses
- Bone fracture
- Tooth fragments
- Changes to nerve sensations

CONSEQUENCES OF NOT PERFORMING TREATMENT: This course of treatment will help to relieve your symptoms. If no treatment were performed, you would continue to experience symptoms, which could include pain and/or infection, deterioration of the bone surrounding your teeth, changes to your bite, discomfort in your jaw joint and possibly the premature loss of these and other teeth.

Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information, and that all of your questions have been answered fully.

____ I give my consent for the proposed treatment as described above

____ I refuse to give my consent for the proposed treatment as described above. I have been informed of the potential consequences of my decision to refuse treatment.

_____ _____

Patient Name (Print) **Date**

_____ _____

Patient or Legal Guardian Signature **Tooth Number (s)**