CONSENT FOR TOOTH REMOVAL

An explanation of your need for tooth removal was discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

Diagnosis: I have been informed of the need for dental extraction (the removal of a tooth or several teeth). The reasons for this extraction have been explained to me.

Suggested Treatment: It has been suggested that the tooth/teeth checked below be removed:

Upper Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Upper Left
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
Lower Right	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Lower Left

Description of the Procedure: After anesthetics have numbed the area to be operated, extraction will be accomplished by either the removal of the tooth/teeth or by surgical reflection of gum, possible removal of some bone around the tooth/teeth, and possible sectioning of tooth roots to facilitate removal of the tooth/teeth. After the extraction, tooth socket(s) (hole in jawbone left by tooth removal) will be inspected, possibly cleansed of debris or infected soft tissue, and when indicated, this soft tissue may be submitted for histological examination to determine if pathology was present. Finally, the gum and socket or gum tissue may be sutured and measures will be taken to reduce bleeding from the extracted area(s) after this procedure.

Risks Related to the Suggested Treatment: Risks related to tooth removal surgery might include, but are not limited to, post-surgical infection, bleeding, swelling, pain, infection, facial discoloration, transient but on occasion permanent numbness of the lip, teeth, chin, or gum, jaw joint injuries or associated muscle spasms, fracture of the tooth/teeth during surgery, retention of part of a root or roots, dislodging of a tooth or part of a tooth into the upper jaw sinus, swallowing of a tooth or fragments of a tooth, sensitivity to hot or cold or sweets or acidic foods, or shrinkage of the gum upon healing. Risks related to the anesthetics might include, but are not limited to, allergic reactions, accidental swallowing/aspiration of foreign matter, facial swelling or bruising, pain, soreness, or discoloration at the site of injection of the anesthetics.

Alternatives to the Suggested Treatment May Include:

1. No treatment, with the expectation of the advancement of my condition resulting in greater risk or complications including, but not limited to, bone loss, pain, infection, and possible damage to the support of adjacent teeth.
2. Root canal treatment, with the expectation that this may not eliminate infection in the area, or that I may still lose the tooth in the near future.
3. Restoration (filling or cap) of this tooth/these teeth with the expectation that it/they may be lost in the near future.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed surgery will be completely successful in eradicating all pre-existing symptoms or complaints. It is anticipated that the surgery will provide benefit in reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth by reducing the problems associated with this tooth/these teeth. However, due to individual patient differences, one cannot

predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition including the possible loss of certain teeth with advanced involvement, despite the best of care.

Consent to Unforeseen Conditions: During surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include, but are not limited to, extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, or termination of the procedure prior to completion of all of the surgery originally scheduled. I therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the treating doctor.

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Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and after thorough deliberation, I give my consent for the performance of any and all procedures related to tooth extraction as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

Compliance with Self-Care Instructions: I understand that excessive smoking and/or alcohol intake may affect healing and may limit the successful outcome of my surgery. I agree to follow instructions related to the daily care of my mouth. I agree to report for appointments as needed following my surgery as suggested so that my healing may be monitored and the doctor can evaluate and report on the outcome of surgery upon completion of healing.

Supplemental Records and Their Use: I consent to photography, video recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

Patient's Signature	Date	Patient's Name
Signature of Patient Guardian	Date	Relationship to Patient
Signature of Witness	Date	