DENTAL CLINIC

Consent for Tooth Extractions and Other Oral Surgeries

I HEREBY GIVE PERMISSION TO _____, D.D.S. TO PERFORM THE FOLLOWING PROCEDURES AND SUCH ADDITIONAL PROCEDURES AS ARE CONSIDERED NECESSARY ON THE BASIS OF FINDINGS DURING SAID PROCEDURE:

EXTRACTION OF TEETH #'S ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

AND/OR _____

I CONSENT THIS TO BE DONE WITH LOCAL ANESTHESIA ONLY AND OTHER MEDICATIONS LISTED BELOW.

A. _____B. _____

THE FOLLOWING ALTERNATIVE METHODS HAVE BEEN EXPLAINED TO ME:

1.
2.
3.

THESE ALTERNATIVE METHODS OF TREATMENT ARE PRACTICAL AND POSSIBLE, BUT I DESIRE THE TREATMENT MENTIONED IN PARAGRAPH #1. I ALSO CERTIFY THE REASONS WHY THE ABOVE-NAMED PROCEDURES ABOVE CARRY CERTAIN COMMON INHERENT RISKS SUCH AS, BUT NOT LIMITED TO:

A} DRUG REACTIONS AND SIDE EFFECTS
B} POST-OPERATIVE BLEEDING
C} POST OPERATIVE INFECTION OR BONE INFLAMMATION (DRY SOCKET).
D} NECESSARY REMOVAL OF BONE DURING TOOTH EXTRACTION.
E} POSSIBLE INVOLVEMENT OF THE SINUS OF THE UPPER JAW DURING REMOVAL OF UPPER BACK TEETH REQUIRING POSSIBLE SURGERY FOR REPAIR AT A FUTURE DATE.
F} POSSIBLE INVOLVEMENT OF THE NERVE WITHIN THE LOWER JAW DURING REMOVAL OF LOWER MOLAR TEETH, RESULTING IN USUALLY TEMPORARY BUT POSSIBLE PERMANENT NUMBNESS AND /OR TINGLING IN THE LOWER LIP, RIGHT AND/OR LEFT SIDE.

I AM AWARE THE PRACTICE OF DENTISTRY AND ORAL MAXILLOFACIAL SURGERY IS NOT AN EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS A RESULT OF THE PROCEDURES AUTHORIZED ABOVE.

_____ _____
DATE FIRST LAST MI (PLEASE PRINT)

_____ _____
WITNESS SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

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