CONSENT FOR DENTAL EXTRACTION AND OTHER GENERAL SURGICAL PROCEDURES IN AND AROUND THE MOUTH

Patient's Name Date

If you have any question, please ask your doctor BEFORE signing.

You have the right to be informed about your condition and the recommended treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you, but is rather an effort to provide information so that you may give or withhold your consent.

My condition has been explained to me as: _____
_____

The procedure(s) necessary to treat the condition(s) has/have been explained to me and I understand the nature of the treatment to be: _____
_____

I have been informed of possible alternate methods of treatment (if any), including:_____
_____
I understand that these other forms of treatment or no treatment at all, are choices that I have and the risks of those choices have been presented to me.

My doctor has explained to me that there are certain inherent and potential risks and side effects associated with my proposed treatment and in this specific instance they include, but are not limited to:

A. Post-operative discomfort and swelling that may require several days of at-home recovery.
B. Prolonged or heavy bleeding that may require additional treatment.
C. Injury or damage to adjacent teeth or fillings.
D. Post-operative infection that may require additional treatment.
E. Stretching of the corners of the mouth that may cause cracking or bruising and may heal slowly.
F. Restricted mouth opening during healing; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.
G. A decision to leave a small piece of root in the jaw or mouth when its removal would require extensive surgery or risk other complications.
H. Fracture of the jaw (usually only in more complicated extractions or surgery).

I. Injury to nerve branches in the jaw or soft tissues resulting in numbness, pain or tingling of the chin, lips, cheek, gums or tongue on the operated side(s). These symptoms may persist for several weeks, months or, in rare instances, may be permanent.

J. Opening of the sinus (a normal chamber situated above the upper teeth) requiring additional surgery or treatment.

K. Dry socket (loss of blood clot from extraction site) could happen which could be painful.

L. Local anesthesia, medications, drugs, anesthesia, and prescriptions may cause allergic reactions, complications, and side effects. They carry the potential risks of brain damage, stroke, heart attack, or death.

M. It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted on this form. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

It has been explained to me, and I fully understand, that a perfect result is not or cannot be guaranteed.

The anesthetic I have chosen for my surgery is:

- ☐ Local Anesthesia
- ☐ Local Anesthesia with Oral Pre-medication
- ☐ Local Anesthesia with Intravenous Sedation (Requires separate consent)
- ☐ General Anesthesia (Requires separate consent)

Medications, drugs, anesthesia, and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle or hazardous devices, do anything that requires attention, or work while taking these medications and/or drugs until fully recovered.

Photographic, video-graphic, and other records: I authorize the taking, viewing, and publication of photos, slides, x-rays, videos, or any other records of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. However, my identity will not be revealed to the general public without my permission.

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INFORMATION FOR FEMALE PATIENTS

I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

CONSENT

I certify that I speak, read and write English and have read and fully understand this consent for surgery, have had my questions answered and that all blanks were filled in prior to my signature.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date