
INFORMED CONSENT FOR EXTRACTION

I understand that there may be alternatives to the extraction of teeth. After considering the various options, I have chosen extraction. I understand that various normal complications can occur despite all efforts to the contrary as a result of the extraction(s), including but not limited to:

- Allergic reaction to medications or anesthetics used in the extraction process
- Pain, swelling, infection, bruising, bleeding
- Stiffness of the adjoining or nearby muscles
- Numbness – There is the possibility of injury to the nerves of the face or tissues of the oral cavity during the administration of anesthetics or during the treatment procedures, which may cause a numbness of the lips, tongue, tissues of the mouth and/or facial tissues. This numbness is usually temporary but may be permanent.
- Fracture of the root tips, which may also result in the root tips being left in place or displacement of the root tip into the sinuses and/or spaces nearby
- Dry sockets, aspiration and/or swallowing of foreign objects
- Damage to adjacent teeth and/or restorations

I further understand that this procedure also can be performed by a specialist and request that this treatment be performed in this office by a general dentist.

The dental care and treatment to be performed has been explained to me, and I understand what is to be done and that there is no warranty or guarantee as to any result and/or cure. I may ask the attending dentist for a more complete explanation.

This is my consent for the extraction, anesthetics and X-rays to be taken.

I have read and understand the above and have had all my questions answered to my satisfaction. I agree to proceed with the recommended extraction(s).

Signature

Date

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