# TOOTH REMOVAL CONSENT FORM

I understand that the extraction of a tooth (teeth)_____ has been recommended

by my dentist Dr _____

I have had any alternative treatment explained to me, as well as the consequences of doing nothing about my dental conditions.

I understand that non-treatment may result in, but not be limited to: infection, swelling, pain, periodontal disease, malalignment and systemic disease/infection if left too late.

I understand that there are risks associated with any dental, surgical, and anesthetic procedure. These include, but are not limited to:

Post-operative infection or inflammation
Swelling, bruising, and pain
Damage to the adjacent teeth, filling or crown
Drug reactions and their potential side effects
Bleeding socket requiring more treatment
Possibility of a small fragment of root or bone being left in the jaw intentionally when its removal is not appropriate (such fragments may work their way partially out of the tissue and need to be removed later)
Delayed healing (Alveolitis or dry socket) necessitating few post-operative visits for dressing the socket with an obtundent (nerve soothing iodine medicament)
Damage to maxillary sinuses requiring additional treatment or surgical repair at a later date
Fracture or dislocation of the jaw
Roots escaping into facial spaces (very rare occurance)
Damage to the nerves during tooth removal resulting in temporary, or possibly partial or permanent numbness or tingling of the lip, chin, tongue, or other areas (occurs in less than 1% of cases)

By signing below, I certify that I understand the recommended treatment, the fee involved, the risks of such treatment, any alternatives and risks of these alternatives, including the consequences of doing nothing.
I have had all of my questions answered, and have not been offered any guarantees

Patient Name & Signature:

Date