Provider: Dr Ash **CONSENT FOR TOOTH REMOVAL (EXTRACTION)**

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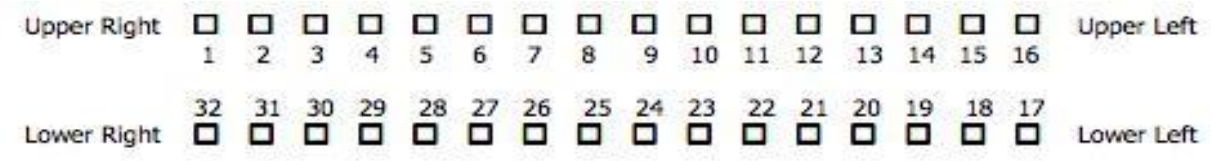
Patient's Name Date

All dental procedures carry with them some degree of risk. I want you to understand the benefits associated with treatment, as well as the risks. This information is not meant to scare or alarm you, it is simply an effort to make you better informed so that you give or withhold your consent to the procedures. During your consultation we discussed your need for extraction(s), steps involved, its purpose, benefits, and the possible complications/risks as well as alternatives. We obtained your verbal consent to undergo this procedure**. Please initial each paragraph after reading, if you have any questions please ask your periodontist before initialing and signing on the last page.**

_____***1. 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 at my consultation appointment.

_____***2. Recommended Treatment.*** It has been suggested that the tooth/teeth checked below be removed:



_____***3. Principal Risks and Complications.*** Taking teeth out is a permanent process. Whether the procedure is easy or difficult, it is still a
surgical procedure. I understand that complications, although rare, may result from tooth/teeth removal surgery and drugs or anesthetics administered. These complications include, but are not limited to:

1. Swelling, pain, and facial discoloration (bruising).
2. Bleeding – significant bleeding is not common, but persistent oozing can be expected for the first 1-2 days.
3. Post-surgical infection or dry socket (loss of blood clot) that might need more treatment.
4. Local anesthetic injection may cause allergic reaction, temporary or permanent injury to nerves and/or blood vessels.
5. During surgery it may be impossible to avoid touching, moving, stretching, or injuring the nerves in my jaw that control sensations and function. This can lead to transient (usually this disappears slowly over several weeks or months) but on occasion permanent numbness, itching, burning, pain or tingling of the jaw, teeth, gums, tongue (including the possibility of loss of taste sensation), lip, chin, cheek, or in areas of the skin of the face.
6. Fracture of the jaws (very rare), 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 or sinus exposure. Sharp ridges or bone splinters may form later at the edge of the hole where the tooth was taken out (may need another surgery to smooth or remove), Loss or injury to adjacent teeth (more often those with large fillings or caps), and soft tissue, swallowing of a tooth or fragments of a tooth, accidental swallowing/aspiration of teeth and restorations.
7. Jaw joint injuries, pain or muscle spasm/stiffness cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, and transient (on rare occasion permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet, or acidic foods or shrinkage of the gum upon healing. The exact duration of any complication cannot be determined, and they may be irreversible.
8. Teeth adjacent to the tooth or implant to be extracted may be chipped, damaged, or lost during the extraction.
9. Extracted teeth that are not replaced may lead to the other teeth moving or drifting, creating spaces between the remaining teeth and making it difficult to impossible to replace them or straighten them later.
10. To my knowledge, I have reported to my doctor any prior drug reactions, allergies, diseases, symptoms, habits, or conditions that might in any way relate to this surgical procedure. I have also told my doctor about any present or prior head and neck radiation therapy and present or prior use of bisphosphonate medications. Some common brand names are Zometa, Aredia, Boniva, Fosamax, and Actonel.
11. Nerves which supply sensation in your mouth, chin, lips, tongue, and gum tissue may run near the area of the extraction. After the extraction you may experience some alteration of normal nerve sensation (itching, burning, or tingling, for example) for a short or indefinite period of time. In some rare instances you may experience a total lack of sensation for a period of time which could be indefinite.
12. For the back teeth in the upper arch there is a risk that following the extraction, a hole or pathway may be present between the sinus and the mouth. This is because the roots of some of the upper teeth are just below the floor of the sinus and sometimes actually go through the sinus floor. If this occurs during your procedure, I may need to make a

small surgical repair of the hole and may place you on antibiotics and antihistamines to reduce the risk of a sinus infection.

13. Following the procedure the muscles of your jaw may be stiff and sore and it may be difficult to open your mouth wide for several days. This is a temporary condition and moist heat and analgesics will usually provide symptomatic relief. You may also experience some cracking or redness in the corners of your mouth.

_____*4. Alternatives to Suggested Treatment.*

A. 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.
B. Extraction of less teeth than indicated
C. Other dental (restorative, periodontal or endodontic) treatment if possible

_____*5. Necessary Follow-up Care and Self-Care.* 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.

_____*6. _No Unforeseen Conditions*. During the course of treatment, unforeseen conditions may be revealed that may require termination or changes in the procedure. I authorize my doctor to use his professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

_____*7. No Warranty or Guarantee.* I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed extraction(s) 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 extraction(s). However, due to individual patient differences, one cannot predict the absolute certainty of success. Therefore, there exists the risk of failure, relapse, selective re-treatment, or worsening of my present condition including the possible loss of certain teeth with advanced involvement, despite the best of care.

_____8. *Use of Records for Reimbursement and Publication Purposes.* I authorize photos, video recordings, x-rays, slides, or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry, educational use in lectures or publications and reimbursement purposes. My identity will <u>never</u> be revealed to the general public., however, without my permission.

_____*9. Females only.* Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills), which can result in pregnancy. Therefore, I understand that I will need to take extra precautions and use some additional form of birth control when taking antibiotics. Furthermore, I have informed my periodontist of my pregnancy and/or nursing status.

PATIENT CONSENT

I have been fully informed of the nature, risks and benefits of the extraction(s) surgery, the alternative treatments available, and the necessity for follow-up care and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the extraction(s) surgery as presented to me during my consultation and as described in this document above. I also consent to additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist. I have given a complete and truthful medical history, including all medications, drug use, allergies, pregnancy and etc. I certify that I have read and fully understand this document.

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Patient's Signature (or patient's guardian) Date

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Witness Signature Date