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Dental Implants • Periodontics

CONSENT FOR TOOTH/TEETH EXTRACTION

Facts for Consideration

Extraction(s) involve removal of one or more teeth. Depending on their condition, this may require the sectioning of teeth or trimming of the gum or bone tissue.

Once the tooth is extracted, you will have a space that you may want to fill with a fixed or removable appliance. Replacement of missing teeth may be necessary to prevent the drifting of adjacent and/or opposing teeth to maintain function, or for cosmetic appearances. The options of a fixed or a removable appliance will be explained to you.

Benefits of Extraction

The proposed treatment should help to relieve your problem, infections or symptoms and may also enable you to proceed with further proposed treatment.

Risks of Extraction

As in any oral surgical procedure, there are some risks of post-operative complications. They include, but are not limited to, the following:

- Swelling, bleeding, bruising or discomfort in the surgical area.
- Post-operative infection requiring additional treatment or medication.
- Tooth sensitivity, tooth mobility (looseness) or tooth pain of neighboring teeth.
- Unaesthetic exposure of crown (cap) margins of neighboring teeth.
- Numbness or altered sensations in the teeth, gums, lip, tongue or chin, around the surgical area following the procedure. Almost always the sensation returns to normal, but in rare cases, the loss may be permanent.
- Limited jaw opening due to the inflammation or swelling. Sometimes it is a result of jaw joint discomfort (TMJ), especially when TMJ disease already exists.
- Stretching of the corners of the mouth resulting in cracking or bruising.
- Damage to adjacent teeth, especially those with large fillings, crowns or bridges.

I understand that the necessary blood clot that forms in the socket may disintegrate or dislodge. This condition, called dry socket, lasts a week or more and is treated by placing a medicated dressing in the tooth socket to aid healing. To avoid developing a dry socket I must not smoke, drink through a straw, chew food in that area, or disturb the socket in any way for the first week of healing.

I hereby certify that I clearly comprehend the nature, purpose, benefits, risks and alternatives to (including no treatment), the proposed procedure(s). I have been given the opportunity to ask questions and they have been answered to my complete satisfaction.

I authorize photos, slides, x-rays or any other viewing 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.

Patient Name/Signature: _____Date: _____

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