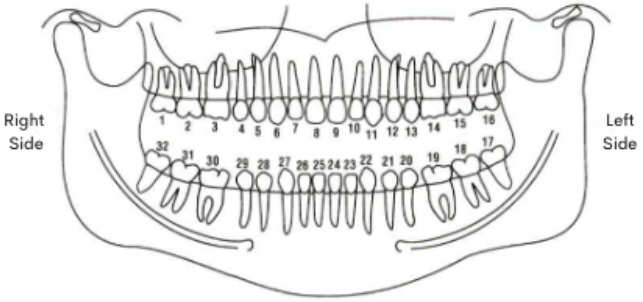
TOOTH EXTRACTION INFORMED CONSENT

_____ _____

Patient's Name Date of Birth

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all of the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor is available to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Adult Teeth



Baby Teeth

Diagram for illustrative purposes only. Teeth to be treated may be indicated on the diagram and/or described below.

Diagnosis: _____

Procedure: _____

Alternative options: _____

_____

1. I have been informed of and understand the potential risks related to this surgical procedure include but are not limited to:
   - Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, retention of tooth structure, bone or foreign material in the body, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials.
   - Nerve injury, which may occur from the **surgical procedure** and/or the **delivery of local anesthesia**, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent and/or require additional treatment.
   - **Dry socket** (slow healing) resulting in jaw pain that increases a few days after surgery.

Patient's Initials _____

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- **Sharp ridges** or **bone splinters** may form where the tooth was removed possibly requiring additional surgery.
- Part of the tooth and/or **roots may be left** to prevent damage to nerves or other structures.
- An opening may occur from the mouth into the nasal or sinus cavities.
- Jaw fracture.
- Bones do not heal properly, which may need additional surgical intervention.
- I understand that bone grafting may be necessary.

2. I have elected to proceed with the anesthesia(s) indicated below.

_____ Local Anesthesia

_____ Nitrous Oxide (Laughing Gas)

_____ Mild Sedation

_____ Moderate Sedation

_____ Deep Sedation (General Anesthesia)

3. Patient's Responsibilities

I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I understand and agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications, risks, or less than optimal results.

I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

If I am sedated or under general anesthesia during the procedure, I further authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness to Patient Signature Date

Patient's Initials _____