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INFORMED CONSENT FOR DENTAL EXTRACTION

Diagnosis: After a careful oral examination, radiographic evaluation and study of my dental condition, my periodontist has advised me that I have a tooth/teeth affected by one or more of the following: gross caries (cavities); gingivitis/periodontitis, infection and/or an abscess.

Recommended Treatment: My periodontist has recommended that a tooth/teeth be extracted. I understand that a local anesthetic will be administered as part of the treatment. I further understand that unforeseen conditions may call for a modification or change from the anticipated treatment including termination of the procedure prior to completion of all the surgery originally outlined. The following treatment will be performed:

- Infected tooth/teeth will be removed.
- Part of the root(s) may be left if it is deemed too traumatic to remove.
- Inflamed and infected gum tissue will be removed.
- Bone regenerative material (grafting) may be placed.

Expected Benefits: The purpose of dental extraction surgery is to reduce infection and inflammation, to restore my gum and bone to the extent possible, and to minimize damage to adjacent teeth.

Principal Risks and Complications: I understand that some patients do not respond successfully to dental extraction surgery. Complications may result from the extraction(s), anesthetics or drugs. These complications include, but are not limited to the following: post-surgical discomfort and swelling for several days or weeks; heavy bleeding; infection requiring additional treatment; dry socket; facial discoloration; tooth sensitivity to hot, cold, sweet or acidic foods; allergic reactions; injury to the nerve underlying the teeth resulting in numbness or tingling of the jaw, lip, tongue, chin, cheek or gum on the operated side for several weeks or months and on rare occasion permanently; jaw joint injuries or associated muscle spasm; stretching, cracking or bruising of the corners of the mouth; opening of the sinus above the teeth requiring additional surgery; restricted ability to open the mouth for several days or weeks; impact on speech; injury to adjacent tissue, teeth, fillings, caps or other dental work; decision to leave a small piece of root in the jaw if its removal would require extensive surgery; bony chips/fragments that may require removal at a later time; future orthodontic treatment; and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. I understand there may be a need for a second procedure if the initial results are not satisfactory.

Alternatives to Suggested Treatment: I understand that alternatives to dental extraction include no treatment. By electing no treatment, my present condition will probably worsen with time and the risks to my health may include, but are not limited to, the following: pain; swelling; severe infection; cyst formation; periodontal (gum) disease; dental decay; malocclusion; and premature loss of teeth and/or bone.

Necessary Follow-Up and Self-Care: I understand that it is important for me to return for follow-up appointments for care and monitoring of the healing process. I also need to continue to see my general dentist for routine dental care and get the missing tooth/teeth replaced as recommended. Smoking may adversely affect healing and may cause a dry socket (which is extremely painful for about one week). Smokers have more dry sockets than non-smokers. If dry socket occurs, I will need to return to the office so my periodontist can treat the condition immediately. I cannot use a water-pik in the extraction site for three months. Failure to follow the recommendations regarding my extraction(s) could lead to ill effects, which would become my sole responsibility.

In addition, the success of the extraction(s) can be affected by medical conditions, dietary and nutritional problems, alcohol consumption, clenching and grinding of teeth, inadequate oral hygiene, and medications that I may be taking.

To my knowledge, I have told my periodontist about any pertinent medical conditions, allergies (especially to medications or sulfites) and medications I am taking, including over-the-counter medications such as aspirin.

I know that it is important to: **(1)** abide by the specific prescriptions and instructions given; **(2)** see my periodontist for post-operative check-ups as needed; **(3)** not smoke or use smokeless tobacco for two weeks; **(4)** avoid water-piks as mentioned above until the site is healed; **(5)** have any non-dissolvable sutures removed; and **(6)** get the tooth/teeth replaced as recommended.

(OVER)

Informed Consent for Dental Extraction - *cont'd.*

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use an additional form of birth control along with my birth control pills for one complete cycle after a course of antibiotics is completed.

Administration of Local Anesthetic: Medications, drugs and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased with the use of alcohol or other drugs; thus I have been advised not to work or operate any vehicle, automobile, or hazardous device while taking medications and/or drugs until fully recovered from their effects.

No Warranty or Guarantee: There is no method that will accurately predict or evaluate how my gum and bone will heal. I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases it should be, however, due to individual patient differences there can never be a certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including possible loss of teeth despite the best of care.

Communication with Insurance Companies and Dental/Medical Providers: I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during and after its completion with my insurance carrier(s), the doctors' billing agency, my general dentist, and any other health care provider involved with my case who may have a need to know about my dental treatment.

PATIENT CONSENT

I certify that I have been fully informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this oral surgery, the alternative treatments available, the necessity for follow-up and self-care, the necessity of notifying my periodontist of any pertinent medical conditions and of any prescription/non-prescription medications I am taking and that there are no guarantees. I have had the opportunity to ask questions in connection with the treatment and to discuss my concerns with my periodontist. I hereby consent to the performance of dental extraction surgery as presented to me during my consultation and as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT BEFORE I SIGNED IT AND CONSENT TO DENTAL EXTRACTION SURGERY.

_____ _____
Signature of Patient (Parent/Guardian) Date

_____
Printed Name of Patient (Parent/Guardian)

_____ _____
Signature of Witness Date

_____
Printed Name of Witness

Initial and Date If Applicable:

Patient: _____; _____; _____
2nd Surgery 3rd Surgery 4th Surgery

Witness: _____; _____; _____
2nd Surgery 3rd Surgery 4th Surgery