TOOTH EXTRACTION CONSENT FORM

Before you give your permission for the removal of teeth, removal of impacted teeth (those that are "buried" or beneath the gums), or other dental treatment, or the administration of certain anesthetics, you should understand that there are certain associated risks.

1. **EXTRACTION**. We will be extracting teeth number(s): ______________________________.

2. **RISKS**. Common risks include but are not limited to:

    - Drug reactions and side effects.
    - Damage to adjacent teeth or fillings.
    - Postoperative infection.
    - Postoperative bleeding that may require treatment.
    - Possibility of a small fragment of root being left in the jaw, and its removal, requiring extensive surgery.
    - Delayed healing (dry socket) necessitating frequent postoperative care.
    - Possible involvement of the sinus during removal of upper molars, which may require additional treatment or surgical repair at a later date.
    - Possible involvement of the nerve, including but not limited to the removal of lower molars, resulting in temporary or possible permanent tingling or numbness, or pain of the lower lip, chin, or tongue on the operated side.
    - Bruising and/or vein inflammation at the site of administration of intravenous medications, which may require further treatment.
    - In rare circumstances, breakage of the jaw.
    - As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness, or even resultant numbness of the tongue, lips, teeth, jaws, and/or facial tissues that is usually temporary. In rare instances, such numbness may be permanent.
    - Other: ____.

3. **ANESTHESIA**. I was given the option of different anesthetic techniques, and I consent for the following anesthetics to be used: (check all that apply)

    ☐ - Local anesthesia (injection).
    ☐ - Local anesthesia (injection) with intravenous sedation.
    ☐ - Local anesthesia (injection) with oral premedication (pills before treatment).
    ☐ - General anesthesia.

4. **CONSENT**. I hereby acknowledge that I understand the recommended treatment, the fee involved, the risks of such treatment, and 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 Signature: ____________________________ Date: _____________
Print Name: ______________________________

Parent/Guardian Signature: ____________________________ Date: _____________
Print Name: ______________________________

Doctor Signature: ____________________________ Date: _____________
Print Name: ____________________________

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