

EXTRACTIONS – DISCUSSION and CONSENT
DENTAL PROFESSIONALS ON WHITESBURG

I am being provided this information and consent form so I may better understand the treatment recommended for me. Before beginning, I wish to be provided with enough information, in a way I can understand, to make a well-informed and confident decision regarding my proposed treatment.

I understand that **I may ask any questions I wish**, and that it's better to ask them before treatment begins than to wonder about it after treatment has started.

Nature of Extraction

It has been recommended that I have the following tooth (teeth) extracted: _____.

Extraction involves the complete removal of a tooth from the mouth. Some extractions may require cutting into the gums and removing supporting bone and/or cutting the tooth into sections prior to removal.

This recommendation is based on visual examination(s), x-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and desires have also been taken into consideration. The extraction is necessary because of:

____ Pain ____ Infection ____ Periodontal (gum disease) ____ Decay
____ Broken Tooth/Teeth ____ Tooth is not restorable ____ Other _____

The intended **benefit** of extraction is to relieve my current symptoms and/or to permit me to continue with any additional treatment my dentist has proposed.

Alternatives to Extraction

Depending on my diagnosis, there may or may not be an alternative to extraction that involves other types of dental care.

____ Tooth # _____ **can** be restored/retained by:

____ Root canal therapy ____ Filling ____ Crown ____ Gum treatment ____ Other treatment (specify)

____ Tooth # _____ **cannot** be restored. Extraction is the only reasonable treatment option.

Risks of Extraction

I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure, including extractions. I understand that during and following treatment, I may experience pain or discomfort, bleeding, swelling, bruising, and stiff jaws, all of which may last for several days. I understand that it is possible for an infection to incur in the extraction site and that I may need antibiotics and/or other procedures to treat the infection. I understand that less common complications include: dry socket (lost blood clot); loss or loosening of dental restorations; loss or injury to adjacent teeth and soft tissues; jaw fractures; sinus exposure (upper teeth); swallowing or aspiration of teeth and restorations.

I understand that small root fragments may break off from the tooth being extracted. Depending on their size and position, they may either be left to remain in the jaw or may require additional surgery for removal.

I understand that if any unexpected difficulties occur during treatment, I may be referred to an Oral Surgeon for further care.

I understand that I will be given a local anesthetic injection and that, in rare instances, patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

Other foreseeable risks not stated above include: _____

Acknowledgement

I have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

I realize that in spite of the possible complications and risks, my recommended extraction/surgery/treatment is necessary. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the operation or procedure.

_____ I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about, including:

Patient's Initials _____

Signed: _____

Patient or Guardian

Date: _____

Signed: _____

Treating Dentist

Date: _____

Signed: _____

Witness

Date: _____