Extraction Consent Form

Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am being provided with this information so I may better understand the treatment recommended for me. **I understand that I may ask any questions** I have and that it is best to ask them before treatment begins.

**Nature of Extraction**

It has been recommended that I have the following tooth (teeth) extracted:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

This recommendation is based on factors that have been discussed with me, and the extraction is necessary because of: □Impacted □Pain □Gum Disease □Decay □ Infection □Tooth is Non-restorable □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Risks of Extraction**

 I have been informed and fully understand that there are 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 jaw joints, all of which may last for several days. I understand that less common complications include: dry socket (lost blood clot); loss of adjacent dental restorations; injury to adjacent teeth and soft tissues; jaw fractures; socket infection; sinus exposure; aspiration (falling into the airway) or swallowing of teeth and restorations.

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

 I understand that during surgery it may be impossible to avoid touching, moving, stretching or injuring the nerves in my jaw that control sensations and function in my lips, tongue, chin, teeth and mouth. This may result in temporary or permanent numbness, itching, burning or tingling.

I have discussed my treatment with Dr. Brian Putman and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment and the risks of refusing treatment.

Signed: ­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient or Guardian