



EXTRACTION INFORMED CONSENT

____ 1. I, the UNDERSIGNED, consent to Dr. _____, his/her partners and/or associates performing on me the following extraction: _____.

____ 2. I hereby acknowledge I have given an accurate report of my past and present physical and mental health history; and, reported all prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, body diseases, gum or skin reaction, abnormal bleeding or any other conditions related to my health

____ 3. I accept and understand the purpose and the nature of the extraction procedure. I also accept and understand what is necessary to accomplish the removal of the tooth/teeth, and all alternatives to this treatment have been fully explained.

____ 4. I accept and understand that if nothing is done, any of the following, but not exclusive of, could occur:
Bone disease; Loss of bone; Gum tissue inflammation; Infection; Sensitivity; Looseness of teeth, followed by evolution of the tooth; Temporomandiblar joint (jaw) problems; Headaches; Referred pains to the back of the neck and facial muscles; or, Tired muscles when chewing.

____ 5. The extraction procedure has been fully explained to me, including all risks and complications involved. I have been fully informed that the risks and complications (the exact duration of which is undeterminable and potentially irreversible) may include, but are not exclusive of:
Pain; Swelling; Infection and discoloration; Numbness of the lip, tongue, chin, cheek, or teeth; Inflammation of a vein; Injury to teeth present; Bone fractures; Sinus penetration; Delayed healing; and/or, Allergic reactions to drugs or medications used.

____ 6. I accept and understand that I elect to have the extraction procedure under:
____ A. Local anesthesia
____ B. Oral sedation
____ C. Nitrous Oxide

____ 7. I accept and understand *there is NO WARRANTY or GUARANTEE of any kind as to any result and/or cure.*

____ 8. I accept and understand that there is no method to accurately predict the gum and the bone healing capabilities in each patient following the extraction.

____ 9. I accept and understand that excessive smoking, alcohol or sugar may effect gum healing and may result in complications related to healing. I agree to follow ALL home care instructions and to show up for ALL examinations as instructed.

____ 10. I have had the opportunity to discuss the extraction procedure, and have had an opportunity to ask questions, and am fully satisfied with the answers received.

____ 11. If, during the extraction procedure, a change in treatment is required to fulfill the complete treatment plan, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

Patient's Signature (or Parent/Guardian): _____ Date: _____