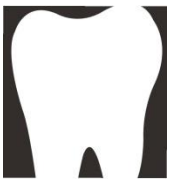

HUNTINGTON SMILES

100 E. Huntington Drive, Suite 206 Alhambra, CA 91801 (626) 308-7881

Extraction Consent Form

Patient Name: _____

Your dentist suggests that the following teeth be removed: _____
For the following reason(s):_____Abscess_____Periodontal disease_____Nonrestorability_____Other

The consequences of not performing necessary extractions may include:

- Continuation, growth, and/or spread of infection
- Pain and swelling
- Systemic infection, such as fever, sepsis, and (in rare cases) death
- Aspiration (inhaling) of loose teeth or tooth fragments

Though rare, the following complications may occur during or after dental extractions:

- Pain and swelling
- Injury to neighboring teeth, restorations, or soft tissues
- Reversible or irreversible nerve damage
- Dry socket (a painful, noninfectious complication)
- Infection
- Adverse reactions to medications, anesthesia, or substances used for the extraction
- Retained fragments of teeth in the jaw (if the risk of removal outweighs the benefit)
- Perforation of the maxillary sinus, possibly requiring further treatment
- In rare cases, fracture of the jaw requiring further treatment

I understand that tooth extraction is an elective procedure, and there are often alternative treatments, such as a root canal and restoration or performing no treatment at all. My dentist has described other options, invited me to ask questions, and I am electing to proceed with the extraction.

I will follow the verbal and written postoperative instructions and return for a follow-up appointment if requested.

Signature of Patient:_____Date:_____

Signature of Doctor:_____Date:_____

Signature of Witness:_____Date:_____