LOVE YOUR SMILE
FAMILY & AESTHETIC DENTISTRY

Patient Initial

DISCUSSION & CONSENT FOR EXTRACTION

Patient's Name: _____ Date of Birth: _____

Nature of Treatment

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 is called surgical extraction).

This recommendation is based on visual examination(s), on any diagnostic imaging, 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 nonrestorable ☐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.

The prognosis, or likelihood of success, of this extraction is _____.

My extraction is estimated to cost $_____ and is estimated to take _____ visit (s) to complete.

Alternatives

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 ❍ Periodontal Treatment ❍Other Treatment: _____
☐ Tooth # _____ is not restorable and 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 occur 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 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 nerve

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Patient Initial

Discussion & Consent for Extraction (page 2)
Risks of Extraction (continued)

disturbances such as temporary or permanent numbness, itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

I understand that extracting the tooth may not relieve my symptoms and that complications may occur. Other treatment or procedures may be necessary.

I understand that I will be given a local anesthetic injection and that in rare situations, 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 the anesthetic injection or from holding my mouth open during treatment.

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 diagnostic imaging.

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 received information about the proposed treatment. I have discussed my treatment with Dr. Beverly Jaiswal 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 risk of refusing treatment.

I understand that the treatment can also be performed by an oral surgeon (specialist) . I understand the risks and elect to have the procedure performed by Dr. Beverly Jaiswal. I understand that if any unexpected difficulties occur during treatment, I may be referred to an oral surgeon for further care.

_____	_____	_____
Patient or Guardian Signature	***Date***	***Time***
_____	_____	_____
Treating Dentist Signature	***Date***	***Time***
_____	_____	_____
Witness Signature	***Date***	***Time***