LOVE YOUR SMILE
FAMILY & AESTHETIC DENTISTRY

Patient Initial

DISCUSSION & CONSENT FOR EXTRACTION WITH SOCKET PRESERVATION

Patient's Name: _____ Date of Birth: _____

Nature of Treatment
It has been recommended that I have the following tooth (teeth) extracted with concurrent ridge preservation:
_____

After anesthetics have numbed the area, the gum is reflected from the jaw bone surface, teeth are removed, the extraction site cleansed of any infected tissue, the graft material placed into the extraction sockets and on the surface of the bone and then a Guided Tissue Barrier Membrane or a collagen plug may be placed over the grafted bone area to prevent gum skin cells from entering the wound and stopping bone regeneration and to aid in the retention of the bone graft. Finally, the gum is sutured back around the teeth and/or together

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:_____

Type of bone graft: ☐ allograft ☐ xenograft ☐ synthetic

Demineralized bone allograft is human bone tissue donated from diseased persons. All donors are screened to prevent transmission of disease to the person receiving the graft. They are tested for hepatitis, syphilis, blood and tissue infections, and HIV. Tissue is recovered and processed under sterile conditions. Processing includes the demineralization of bone and its preservation by the process of freeze drying. Xenograft is bone processed similar to the above descriptions after harvesting from bovine or porcine sources. Synthetic bone are artificial bone like substances.

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 intended benefit of socket preservation is to preserve the existing surrounding bone either in preparation for an implant surgery in the future or to improve the soft tissue esthetics of the extraction site.

The prognosis, or likelihood of success, of this procedure 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.

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Patient Initial

Discussion & Consent for Extraction with Socket Preservation (page 2)
Risks of Procedure (continued)

Risks of Procedure

I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure, including extractions. Risks related to surgery with extraction and ridge bony regeneration by the use of bone grafts might include, but are not limited to: fracture of the tooth/teeth during extraction, retention of part of a root/roots, dislodging of tooth or part of tooth into the upper jaw sinus, post surgical infection, bleeding, swelling, pain, facial discoloration, transient but on occasion permanent numbness of lip, tongue, teeth, chin, or gum, jaw joing injuries or associated muscle spasms, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot or cold or sweets or acidic foods, shrinkage of gum upon healing (which could result in elongation of and/or greater spaces between some teeth). Risks related to anesthetics might include, but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain or soreness or discoloration at the site of injection of anesthetics.

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 or periodontist (specialists). 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***