Jain Dental Care

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Tooth Extraction Consent Form

Regarding patient: _____

This is my consent for Dr. _____ to perform the following treatment which has been explained to me to be advisable or necessary:

Extraction of tooth/teeth #_____.

Alternatives to this treatment include: _____.

- no alternative due to hopeless prognosis for tooth/teeth

I understand that once the tooth is removed, there will be a space remaining that may or may not require replacement. It has been explained to me that there are certain inherent and potential risks in any treatment involving the extraction of a tooth.

The following are likely with most extractions:

1. postoperative discomfort, sometimes necessitating several days of home recuperation
2. swelling
3. bleeding that may be prolonged

The following occasionally occur:

4. injury to adjacent teeth, crowns, or fillings (e.g.- lost restoration, fractured tooth)
5. postoperative infection requiring additional treatment
6. restricted mouth opening for several days or weeks
7. the decision to leave a small piece of root in the jaw when its removal would require extensive surgery, even if such surgery is necessary at a later time
8. creation of an opening into the sinus cavity above the upper teeth
9. referral to a specialist for continued or follow-up treatment should it be advisable or necessary

The following infrequently occur:

10. breakage of the jaw
11. injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side, persisting for several weeks, months, or in some cases permanently.

I certify that I have had an opportunity to read and fully understand the above consent. I grant the above-named dentist permission to extract the above listed tooth/teeth.

Signed: _____

Name: _____

Date: _____