DISABILITY DENTAL SERVICES

Patient Name_____

EXTRACTION: INFORMED CONSENT

Please read and sign for possible extraction at the clinic.

REASON FOR RECOMMENDING EXTRACTION OF A TOOTH

- Severe periodontal disease or 3rd molars(wisdom teeth)
- Irreversible damage to the nerve tissue inside the tooth
- Failed endodontic therapy
- Extreme fracture or decay of the tooth surface

I have been informed of the reason for extractions, and have been explained what to expect during this procedure. I understand that dental radiographs will be required prior to this extraction, and possibly during the procedure. I understand that I will require an anesthetic and that sutures may be necessary. I have been given and understand the post-operative instructions. I also understand that if I have been given an antibiotic medication, that I am to take it until the entire prescription is completely finished. If I have been prescribed a pain medication, I will take it only if necessary. If the pain medication contains a narcotic such as codeine, operating machinery or driving a motor vehicle will be dangerous and could cause harm to myself or others.

I can expect bleeding from the extraction site for the first 24 hours.

SOME COMPLICATIONS OF ROUTINE EXTRACTIONS INCLUDE (BUT ARE NOT LIMITED TO)

- Fracture of adjacent teeth or restorations
- Post-operative pain slight, moderate, or severe and lasting from hours to days
- Swelling at and around the extraction site
- Separated root tips or fragments, separated bone fragments
- Temporary or permanent nerve damage to the area resulting in numbness
- Incomplete healing resulting in severe pain (dry socket)
- Fracture of the surrounding bone

IF YOU HAVE ANY QUESTIONS ABOUT THE REASON FOR THIS EXTRACTION, PLEASE FEEL FREE TO ASK.

I HAVE READ THE ABOVE INFORMATION AND GIVE MY PERMISSION TO HAVE THE TEETH EXTRACTED IF NEEDED.

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Signature of Patient, Guardian, or Personal Representative Date

_____ _____

Signature of Witness for Patient Signature Date