Informed Consent for Extraction of Teeth

Dentist: Dr. Kaushali Patel　　Patient: ____________

Tooth #: ____________

FACTS FOR CONSIDERATION

Extraction involves permanently removing one or more teeth from your mouth. Extraction of teeth may involve cutting the tooth to be extracted and/or the gums around the teeth. Extraction of teeth may also involve removal of surrounding bone and infected gum tissue. Sutures (stitches) may be placed following extraction of teeth. If any unexpected difficulties occur during treatment, you may be referred to an Oral Surgeon, who is a specialist in dental surgery. Once a tooth is extracted, you may have a space between your remaining teeth. This space may be filled with an implant, or with a fixed (cemented) bridge or removable partial denture (appliance). Replacement of missing teeth may be necessary to prevent the drifting of adjacent and/or opposing teeth, to maintain chewing function, to support the jaw joint (TMJ) and for cosmetic purposes. In most cases, extracting teeth leaves a substantial hole in the jawbone, which slowly fills in and re-shapes over time as a permanent defect. A bone graft is usually recommended to minimize this defect and replace bone lost due to the extraction.

I understand that if no treatment is performed I may continue to experience symptoms which could include pain and/or infection, deterioration of the bone surrounding my teeth, changes to my bite, discomfort in my jaw joint, and possibly premature loss of other teeth. In addition, I am aware that if nothing is done an inability to place a bone graft or implants at a later date is likely due to changes in oral or medical conditions.

________ (Initials)

RISKS OF EXTRACTING TEETH, NOT LIMITED TO THE FOLLOWING

As in all surgical procedures, Extracting Teeth is not without some risk. Since each person is unique and responds differently to surgery, the healing process may vary; no guarantees can be made. I have been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include but are not limited to pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are thrombophlebitis (inflammation of the vein), injury to teeth present, bone fractures, sinus penetration, delayed healing, allergic reactions to drugs or medications used, etc.

I understand that I will receive a local anesthesia and/or other medication. I agree to the type of anesthesia prescribed, according to the choice of the doctor. In rare instances patients have a reaction to the anesthetic which may require emergency medical attention at my cost. Sometimes patients find that local anesthesia reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. Rarely, temporary, or permanent nerve injury can result from an injection.

Depending on the anesthesia and medications administered, I may need a designated driver to take me home. In this case, I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more or until fully recovered from the effects of the anesthesia or drugs given for my care.

I understand that following treatment I may experience bleeding, pain, swelling, and discomfort for several days, which may be treated with pain medication. It is possible infection can follow Extraction of Teeth and must be treated with antibiotics or other procedures. I will contact the office immediately if symptoms persist beyond a few days or worsen. I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and make it difficult for me to open wide for several days afterwards. However, this can occasionally be an indication of a further problem. I must notify the dental office if this or other concerns arise.

I agree to follow all post-operative instructions as given to me either orally or in writing and to report to my doctor for follow-up examinations as instructed. I understand that smoking, alcohol consumption, or elevated blood sugar or blood pressure may adversely affect gum healing and/or prolong bleeding. I understand that during normal healing a blood clot forms in the socket left from the extracted tooth. Trauma to the surgical site, smoking, drinking through a straw, and/or heavy exertion may cause this blood clot to disintegrate or dislodge causing a painful condition called Dry Socket. Dry Socket delays healing may last a week or more and is treated by placing a medicated dressing in the tooth socket at the dental office every few days and may require that I take antibiotics. To protect against Dry Socket I must not smoke, drink through a straw, rinse with water or mouthwash, chew food in the surgical area, or disturb the extraction socket in any way for 72 hours.

I understand that the instruments used in extracting a tooth may unavoidably chip, damage or remove crowns from adjacent teeth, which could require further treatment to restore their appearance or function. I understand that upper teeth have roots that may extend close to the sinuses. Removing these teeth may temporarily leave an opening into the sinus. Antibiotics and additional treatment may be needed to prevent a sinus infection and to help this opening to close. I understand that an extraction may cause a fracture in the surrounding bone. Occasionally the tooth to be extracted may be fused to the surrounding bone. In both situations, additional treatment is necessary. Bone fragments called "spicules" may arise at the site following extraction and may need to be removed. I understand that tooth fragments may be left in the extraction site following treatment due to the condition and position of the tooth/teeth. Generally, this causes no problems, but on rare occasions the fragments become infected and must be removed.

I understand that the nerves that provide sensations in my teeth, gums, tongue, lips, and chin run through my jaw. Depending on the tooth to be extracted (particularly lower or wisdom teeth), occasionally it may be impossible to avoid touching, moving, bruising, cutting, or severing a nerve. This could change the normal sensations in any of these areas causing itching, tingling, burning, or the loss of all sensation. These changes could last from several weeks to several months or in some cases indefinitely.

I request and authorize medical/dental services for myself, including Extraction of Teeth and other required related surgeries. I fully understand the contemplated procedure, surgery, or treatment and that conditions may become apparent which warrant, in the judgment of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment. I approve any modifications in design, materials, or care, if my doctor determines this is for my best interest. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated I further authorize and direct my doctor, associate or assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with the Extraction of Teeth procedure.

________ (Initials)

BENEFITS OF EXTACTING TEETH, NOT LIMITED TO THE FOLLOWING

The proposed treatment should help to relieve your symptoms and may also enable you to proceed with further treatment.

________ (Initials)

ALTERNATIVE TREATMENTS IF EXTRACTION IS NOT THE ONLY SOLUTION, NOT LIMITED TO THE FOLLOWING

My doctor has carefully examined my mouth. I understand that depending on my diagnosis, alternatives to Extraction of Teeth may exist which involve other disciplines in dentistry. I have asked my dentist about these alternatives and their respective costs. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs.

________ (Initials)

Dentist: Dr. Kaushali Patel

Patient:

Tooth #:

In conclusion, I understand that each person and treatment situation is unique, and therefore, no guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve the condition(s) listed above. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. I understand if I have taken or take medication for osteoporosis or bone cancer treatment that is a bisphosphonate (such as but not limited to: Zometa, Aredia, Fosamax, Boniva, Actonel), on rare occasions osteonecrosis (lack of blood to the jaw bone cells cause these cells to die) of the jaw may occur after an extraction. Therefore, it is critical that I tell my dentist of all medications and vitamins I am currently taking, which I have done.

	Initials
I consent to the proposed treatment in the dental office as described above.	________
I have been informed of and accept the consequences if no treatment is administered.	________
or	
I refuse to give my consent for the proposed treatment as described above.	________

By signing below, I acknowledge that I have received adequate information about the proposed treatment, that I understand this information, and that all my questions have been answered to my satisfaction.

Signature of Patient / Parent / Guardian

Date

FOR COMPLETION BY DENTIST

I attest that I have discussed the risks, benefits, consequences, and alternatives to proposed treatment with my patient who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

Signature of Dentist

Witness