Extraction Consent

Alternatives to removal of teeth have been explained to me (root canal therapy, crowns. And periodontal surgery .etc. & also option for referral to oral surgeon for examination and treatment is offered, an oral surgeon is specialized in performing this type of procedures. I understand that Dr Patel is general dentist not an oral surgeon.

I authorize the dentist to remove above mentioned teeth. I understand that during treatment it may necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, I give permission to dentist to make any/all changes and additions as necessary.

1. I also authorize and additional procedures deemed necessary in his judgment to accomplish any optimal result consent to the administration of local anesthesia and/or any medication deemed necessary before, during and after the surgery.

2. I understand that there are possible side effects of allergic reactions to any medication including nausea, vomiting, constipation, dizziness, itching, hives, swelling of tongue, lips or face, breathing difficulty, cardiac arrest, anaphylactic shock (severe allergic reaction)

3. I understand these are the possible effects of the procedure:

- Pain, discomfort, bruising, sore throat, difficulty in swallowing that may last several days of weeks.

- Stretching or abrasion of the lips or corners of the mouth resulting in the soreness, pain and difficulty in opening mouth or eating.

- Swallowing or aspiration of part of the tooth, filling or debris.

- Injury to adjacent teeth resulting in sensitivity to cold foods and liquids for weeks.

- Post-operative infection, restricted mouth opening lasting several days.

- Bone spicules or sharp edges of bone or food debris causing pain, inflation, swelling or infection, dry socket or a painful socket requiring several dressing changes.

- For upper teeth opening into the sinus or nasal cavity or sinus infections.

- Numbness of the lip, chin, cheek, face, gum and/ or tongue with loss of taste that usually resolves in weeks but could remain permanent.

- Decision to leave small root tips in the jaw when its removal could damage the nerve or sinus.

- Temporomandibular joint dysfunction and pain.

- Fracture of the jaw surrounding the tooth.

I certify that the medical history I have given is accurate and complete to the best of my knowledge. I understand the practice of oral surgery is not an exact science and no guarantees have been made to me concerning the results of the procedure. I realize in spite of the possible complications, my completed surgery is necessary and I understand the risks and benefits of this procedure including the option of no treatment at all.

I agree to follow all the instructions given to me. I agree to contact the dentist at any time for any problems during and after my procedure

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY, AND ALL QUESTIONS ABOUT THE PROCEDURE HAVE BEEN ANSWERED TO MY SATISFACTION. BY MY SIGNATURE BELOW I CONSENTTO THE TREATMENT DESCRIBED IN THIS PAPER.
