CONSENT FORM: EXTRACTION OF TEETH

Part 1 - Patient & Doctor Information

Patient Name: _____

Doctor Name: _____

In order for me to make an informed decision about undergoing a procedure, I should have certain information about the proposed procedure, the associated risks, the alternatives and the consequences of not having it. The doctor has provided me with this information to my satisfaction. The following is a summary of this information. This form is meant to provide me with the information I need to make a good decision; it is not meant to alarm me.

Part 2 - Details of Consent

Condition

My doctor has explained the nature of my condition to me: Disease of teeth.

Procedure – Extraction of these teeth:_____

My physician has proposed the following procedure to treat or diagnose my condition: Extraction of these teeth: _____This means: Removal of teeth, an irreversible process.

Extraction involves the complete removal of a tooth from the mouth. Some extractions require cutting into the gums and removing bone and/or cutting the tooth into sections prior to removal. The intended benefit of this treatment is to relieve my current symptoms and/or permit further planned treatment. The prognosis for this procedure is _____.
I have been informed of the following possible alternative treatments, and the costs risks & benefits of each:
_No treatment _Root Canal therapy _Filling _Crown _Gum treatment_Other_____.

Alternatives

My physician has explained the following medically acceptable alternatives to be:
Also, I can seek specialized care somewhere else, or I can have nothing done.

Consequences of not having procedure

If I don't have the procedure, my condition may stay the same or even improve. However, it is the doctor's opinion that the proposed procedure is a better option for me.

Other procedures

During the course of the procedure, the doctor may discover other conditions that require an extension of the planned procedure, or a different procedure altogether. I request the doctor to do the procedures my doctor thinks are better to do at this sitting rather than later on.

Risks

The doctor will give his best professional care toward accomplishment of the desired results. The substantial and frequent risks and hazards of the proposed procedure are: Dry socket – jaw pain beginning a few days after surgery, usually requiring additional care (more common from lower extraction, especially wisdom teeth, and in smokers); gum shrinkage (possibly exposing crown margins); change These are usually temporary. Uncommonly, these effects may persist. Uncommon risks also include: Sharp ridges or bone splinters may form later at the edge of the socket, requiring surgery to smooth or remove them. Incomplete removal of tooth fragments – to avoid injury to vital structures such as nerves or sinuses, sometimes small root tips may be left in place. Sinus involvement: the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus, or an opening may occur into the mouth which may require additional care. Complications of therapy may include infection, loss of fillings, injury to other teeth or soft tissues, jaw fracture, sinus exposure, or swallowing or aspiration of debris.

I understand that small root fragments may break off from the tooth being extracted, and that these fragments may be left in the jaw or may require additional surgery for removal. I understand that during surgery it may be impossible to avoid touching, moving, stretching, or injuring the nerves in my jaw that control sensations and function in my lips, tongue, chin, teeth, and mouth. This may result in nerve disturbances such as temporary or permanent numbness, itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

I understand that I will be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand the injection areas may be uncomfortable following treatment, and that my jaw may be stiff and sore from holding my mouth open during treatment.

Drugs, Medications, and Anesthesia

Antibiotics, pain medication, and other medications may cause adverse reactions such as redness and swelling of tissues, pain, itching, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac arrest, which can be increased by the effect of alcohol or other drugs, blood clot in the legs, heart, lungs or brain, low blood pressure, heart attack, stroke, paralysis, brain damage. Sometimes after injection of a local anesthetic, I may have prolonged numbness and/or irritation in the area of injection. If I use Nitrous Oxide, Atarax, Chloral hydrate, Xanax, or other sedative, possible risks include, but are not limited to, passing out, severe shock, and stopping breathing or heartbeat. I will arrange for someone to drive me home from the office after I have received sedation, and to have someone watch me closely for 10 hours after my dental appointment to observe for side effects such as difficulty breathing or passing out.

Implant Database

If a device is placed in my body, the doctor may give my name, dental information, social security number and other personal information to the device manufacturer for quality control purposes.

No guarantee

The practice of dentistry and surgery is not an exact science. Although good results are expected, the doctor has not given me any guarantee that the proposed treatment will be successful, will be to my complete satisfaction, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, relapse, need for more treatment, or worsening of my present condition despite careful treatment. Occasionally, treated teeth may require extraction.

Part 3 - My Responsibility

I agree to cooperate completely with the doctor's recommendations while under his/her care. If I don't fulfill my responsibility, my results could be affected.

Success requires my long-term personal oral hygiene, mechanical plaque removal (daily brushing and flossing), completion of recommended dental therapy, periodic periodontal visits (dental clinic care), regular follow-up appointments and overall general health.

There may be several follow-up clinical visits for the first year following surgery. It is my responsibility to see the doctor at least once a year for evaluation of implant performance and oral hygiene maintenance.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

Necessary Follow-up Care and Self-Care. Natural teeth and appliances should be maintained daily in a clean, hygienic manner. I should follow post-operative instructions given after surgery to ensure proper healing. I will need to come for appointments following the procedure so that my healing may be monitored and so that my doctor can evaluate and report on the outcome of the surgery upon completion of healing.

I will not drink alcohol or take non-prescribed drugs during the treatment period. If sedation or general anesthesia is used I will not to operate a motor vehicle or hazardous device for at least 24 hours or more until full recovered from the effects of the anesthesia or drugs.

I will let the doctor's office know if I change my address so I can be contacted for any recalls.

Part 4 - Miscellaneous

Photography

I give permission for persons other than the doctors involved on my care and treatment to observe this operation (such as company representatives and dentists who are learning the procedure) and I consent to photography, filming, recording and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Miscellaneous

If teeth are removed during treatment, they may be retained for training purposes and then disposed of sensitively.

Fees

I know the fee that I am to be charged. I am satisfied with it and know that it does not include additional post-operative x-rays, injections or anesthetics that may later be necessary to correct any complications. As a courtesy to me, the office staff will help prepare and file insurance claims should I be insured. However, the agreement of the insurance company to pay for medical expenses is a contract between myself and the insurance company and does not relieve my responsibility to pay for services provided. Some and perhaps all of the services provided may not be covered or not considered reasonable and customary by my insurance company. I am responsible for paying all co-pays and deductibles at the time services are rendered and all costs that have not been paid for by my insurance within 45 days. Otherwise, all payments are due at the time services are rendered. All accounts not paid in full within 90 days shall accrue interest at the rate of 18% per year. I will be liable for all collection costs, including court costs and attorney fees.

Part 5 - Signature

Understanding

I read and write English. I have read and understand this form. All blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.
I have been encouraged to ask questions, and am satisfied with the answers. I have read this entire form. I give my informed consent for surgery and anesthesia.

Someone at the doctor's office has explained this form, my condition, the procedure, how the procedure could help me, things that can go wrong, and my other options, including not having anything done. I want to have the procedure done.

I authorize Dr. _____ or his designee (referred to in the rest of this form as the doctor) to perform the procedure listed in the title above.
I know that I am free to withdraw from treatment at any time.

▶ _____ _____

Patient or Representative Signature Date

If not the patient, what is your relationship to the patient?

_____

I have explained the condition, procedure, benefits, alternatives, and risks described on this form to the patient or representative.

▶ _____ _____

Dentist Signature Date