

INFORMED CONSENT

Extraction

I understand that the extraction of one or more of my teeth includes certain risks and possible unsuccessful results. I agree to assume those risks. I also understand that this procedure can be performed by an oral surgeon (a dental specialist). Although great care and diligence will be exercised in this treatment, no promises or guarantees for desired results can be made or expected.

Alternatives to extraction: Depending on my diagnosis, there may or may not be an alternative to extraction that involves other types of dental care. My tooth (teeth) may be able to be saved by root canal therapy, crown, gum treatment, etc. If there is an alternative to this procedure, it has been explained to me and I have chosen the option of an extraction.

Risks of Extraction: I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure, including extractions. I understand that during and following treatment I may experience pain or discomfort, bleeding, swelling, bruising, and stiff jaws, all of which can last for several days. I understand that it is possible for an infection to occur in the extraction site and that I might need antibiotics and/or other procedures to treat the infection. I understand that less common complications include: dry socket (lost blood clot); loss or loosening of dental restorations; loss or injury to adjacent teeth and soft tissues; jaw fractures; sinus exposure (upper teeth); swallowing or aspiration of teeth and restorations. I understand that small root fragments may break off from the tooth being extracted. Depending on their size and position, they may either be left to remain 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 extracting the tooth may not relieve my symptoms and that complications can occur. Other treatment or procedures may be necessary.

Acknowledgement: I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays. I realize that in spite of the possible complications and risks, my recommended extraction/ surgery/ treatment is necessary.

Informed consent: I have been given the opportunity to ask any questions regarding the nature and purpose of an extraction and have received answers to my satisfaction. I voluntarily assume any and all possible risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Phillips and/or his associates to render any treatment deemed necessary, desirable and/or advisable to my dental conditions.