CONSENT FOR TOOTH EXTRACTION

Diagnosis: After a careful oral examination and study of my dental condition, my periodontist has advised me that it may not be possible to save one or more of my teeth.

Recommended Treatment: In order to treat the condition, my periodontist has recommended that one or more of my teeth be removed. This procedure may involve surgery to remove tooth/teeth.

Procedure: I understand that sedation may be utilized and that a local anesthetic will be administered to me as part of my treatment. My gum may be opened, the bone surrounding my teeth may have to be reduced and my teeth may have to be sectioned into pieces for easy removal. The gum and soft tissue may be stitched closed. A periodontal bandage or dressing may be placed. I further understand that my periodontist will make a professional judgement on the management if the situation. The procedure also may involve supplemental bone grafts or other types of grafts to build up the ridge of my jaw.

Principal Risks and Complications: I understand that complications may result from tooth extractions, drugs, or aesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting elongation of some teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

Necessary Follow-Up Care and Self-Care: I understand that it is important for me to return for follow-up visits. The extraction area and any appliances placed to replace missing teeth have to be maintained daily in a clean hygienic manner. The extraction area and appliances must also be examined periodically and may need to be adjusted. I understand that it is important for me to abide by the specific prescriptions and instructions given by my periodontist.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. Due to individual patient differences, however, a periodontist cannot predict the absolute certainty of success. There exists the risk of failure, relapse, additional treatment, or worsening of my present condition, including the possible loss of certain teeth, despite the best of care.
**Publication Records:** I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.
PATIENT CONSENT

I have been fully informed of the need for extraction of the following tooth/teeth:

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I have also been fully informed of the procedure to be utilized, the risks and benefits of periodontal surgery, the alternative treatments available, and the necessity for follow-up and self-care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the removal of the tooth/teeth indicated above. I also consent to the performance of such additional or alternative procedures as may be necessary in the best judgement of my periodontist.

I also give my permission to receive supplemental bone grafts or other types to build up the ridge of my jaw. I also understand that the responsibility to replace the extracted teeth is my own.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

__________________________________________________________
Patient's Name and Signature                                      Date

__________________________________________________________
Witness's Name and Signature                                      Date