INFORMED CONSENT for EXTRACTIONS

WATSONVILLE FAMILY DENTAL
high-quality & cost-effective dental care, without exception

Patient: _____ Date of Birth: _____

Please initial the appropriate paragraphs below.

Facts for Consideration

_____ An extraction involves removing one or more teeth. Depending on their condition, this may require sectioning the teeth or trimming the gum or bone tissue. If any unexpected difficulties occur during treatment, I may refer you to an oral surgeon, who is a specialist in dental surgery.

_____ Once the tooth is extracted, you will have a space that you may want to fill with a fixed or removable appliance. Replacement of missing teeth may be necessary to prevent the drifting of adjacent and/or opposing teeth to maintain function, or for cosmetic appearances. The options of a fixed or a removable appliance will be explained to you.

_____ As in all surgical procedures, extractions entail risk. Since each person is unique and responds differently to surgery, the healing process may vary; no guarantees can be made.

Benefits of Extraction Include:

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

Risks of Extraction Include:

_____ **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 and must be treated with antibiotics or other procedures. I will contact the office immediately if symptoms persist or worsen.

_____ **I understand** that I will receive a **local anesthetic and/or other medication**. In rare instances patients have a reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. Depending on the anesthesia and medications administered, I may need

a **designated driver to take me hom**e. Rarely, temporary or permanent nerve injury can result from an injection.

_____ **I understand** that all **medications** have the potential for accompanying risks, side effects, and drug interactions. **I have disclosed all medications I am currently taking to my dentist, which are:**

_____

_____ **I understand** that holding my mouth open during treatment may temporarily leave my **jaw feeling stiff and sore** and may make it difficult for me to open wide for several days. However, this can occasionally be an indication of a further problem. **I must notify your office** if this or other concerns arise.

_____ **I understand** that the necessary blood clot that forms in the socket may disintegrate or dislodge. This painful condition, called **dry socket**, lasts a week or more and is treated by placing a medicated dressing in the tooth socket to aid healing. To protect against developing dry socket I must not smoke, drink through a straw, rinse with water or mouthwash, chew food in that area, or disturb the socket in any way for 24 to 48 hours.

_____ **I understand** that the instruments used in extracting a tooth may **unavoidably chip or damage 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 a small opening into the sinuses. Antibiotics and additional treatment may be needed to prevent a sinus infection and 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 are generally easily 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 control sensations in my teeth, gums, tongue, lips and chin run through my jaw. Depending on the tooth to be extracted (particularly lower teeth or third molars), occasionally it may be *impossible* to avoid **touching, moving, stretching, bruising, cutting or severing a nerve.** This could change the normal sensations in any of these areas, causing itching, tingling

or burning, or the loss of all sensation. These changes could last from several weeks to several months or in some cases, indefinitely.

Consequences if No Treatment Is Administered Include:

_____ **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 the premature loss of other teeth.

Alternative Treatments if Extraction Is Not the Only Solution Include:

_____ **I understand** that depending on my diagnosis, **alternatives to extraction** may exist which involve other disciplines in dentistry. I asked my dentist about them and their respective costs. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs. **Alternatives discussed**: _____

I declare no guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

□ **I give my consent for the extraction of tooth number(s)_____ as described above by my treating dentist.**
□ **I refuse to give my consent for the proposed treatment as described above.**
□ **I have been informed of and accept the consequences if no treatment is administered.**

_____
Patient's Signature Date

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

_____
Dentist's Signature Date