NORTH BETHESDA PERIODONTAL GROUP

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DIPLOMATES AMERICAN BOARD OF PERIODONTOLOGY

Consent for Extraction

Patient Name: _____ Date: _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

Extraction of teeth is an irreversible process and, whether routine or difficult, is a surgical procedure. As in any surgery, there are some risks. They include, but are not limited to, the following:

_____ Swelling and/or bruising and discomfort in the surgery area.
_____ Stretching of the corners of the mouth resulting in cracking or bruising.
_____ Possible infection requiring additional treatment.
_____ Dry Socket – Jaw pain beginning a few days after surgery, usually requiring additional care. It is more common from lower extractions, especially wisdom teeth.
_____ Possible damage to adjacent teeth especially those with large fillings or caps.
_____ Numbness, pain or altered sensations in the teeth, gums, lip, tongue (including possible loss of taste sensation) and chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or damaged. Almost always sensation returns to normal, but it may take weeks, months or years, in rare cases the loss may be permanent.
_____ Trismus – Limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes it is a result of jaw joint discomfort (TMJ), especially when TMJ disease already exists.
_____ Bleeding – Significant bleeding is not common, but persistent oozing can be expected for several hours.
_____ Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.
_____ Incomplete removal of tooth fragments – To avoid injury to vital structures such as nerces or sinus, sometimes small root tips may be left in place.
_____ Sinus involvement – The roots of the 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 that may require additional care.
_____ Jaw Fracture – while quite rare, it is possible in difficult or deeply impacted teeth.

- Teeth to be removed: _____
- Alternative treatment: _____

CONSENT: I understand that no guarantee as to results (functional, aesthetic, or otherwise) can be or has been promised. I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed surgery and anesthesia. I certify that I speak, read and write English.

PLEASE ASK THE DOCTOR OR ANY OF THE STAFF IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT.

Patient (Or Legal Guardian) Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Witness Signature: _____ Date: _____