KNOX MOUNTAIN DENTISTRY

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Consent to Perform Extraction of Teeth # _____

I understand that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to:

1. **Swelling, bruising and pain**: This can occur with any surgery and vary from patient to patient and from one surgery to another.

2. **Trismus**: This is limited opening of the jaws due to inflammation and/ or swelling in the muscles. This is most common with impacted tooth removal but it is possible with any surgery.

3. **Infection**: This is possible with any surgical procedure and may require further surgery and/ or medications if it does occur.

4. **Bleeding**: Although significant bleeding can occur during or after surgery, it is not common. Some bleeding is, however, usual for most surgeries and is normally controlled by following the post-op instruction sheet.

5. **Drug reactions**: A reaction is possible from any medication given and could include nausea, rash, anaphylactic shock and/ or death. It is now appreciated that antibiotics will inactivate most birth control pills. Sexually active women who take birth control pills should use another method of contraception for the remainder of the menstrual cycle if antibiotics are prescribed.

6. **TMJ dysfunction**: This means the jaw joint (temporomandibular joint) may not function properly and, although rare, may require treatment ranging from use of heat and rest to further surgery.

7. **Reaction to local anesthetic:** Certain possible risks exist that, although uncommon or rare, could include pain, swelling, bruising, infection, nerve damage, idiosyncratic or allergic reactions. In very rare and unpredictable cases the reactions to anesthesia medications can be life threatening.

8. **Dry socket**: This is significant pain in the jaw and ear due to loss of the blood clot and most commonly occurs after the removal of lower wisdom teeth, but is possible with any extraction. It occurs more frequently in patients who smoke after surgery. This may require additional office visits to treat.

9. **Stretching of the corners of the mouth with resultant cracking and bruising:** This may occur due to retraction of the cheeks during surgery.

10. **Damage to other teeth and/or dental restorations**: Due to the close proximity of the teeth, it is possible to damage other teeth and/or dental restorations when a tooth is removed.

11. **Sharp ridges or bone splinters**: Occasionally, after an extraction, the edge of the socket will be sharp or a bone splinter will come out through the gum. This may require another procedure to smooth the bone or remove the bone fragment.

12. **Incomplete removal of tooth fragments**: There are times the doctor may decide to leave a small fragment or root of a tooth in order to avoid damage to adjacent structures such as nerves, sinuses, etc., or when removal would require extensive further surgery.

13. **Numbness**: Due to the proximity of roots of lower teeth to the nerve, it is possible to bruise or damage the nerve with removal of a tooth. The lip, chin and/ or tongue could feel numb, tingling or have a burning sensation. This could remain for days, weeks, or very rarely, permanently.

14. **Sinus involvement**: Due to the location of the roots of the upper teeth to the sinus, it is possible that an opening may develop from the sinus to the mouth or that a root may be displaced into the sinus. A possible infection could develop and may require medication and/ or later surgery to correct.

I consent to administration of local anesthesia as deemed necessary by the dentist to accomplish the proposed procedure.

I understand that certain risks are inherent in any anesthetic or sedation procedure. If any unforeseen condition should arise in the course of the procedure, calling for the doctor's judgement or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he may deem advisable.

No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective retreatment or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition would occur sooner without the recommended treatment.

I have had an opportunity to discuss with the doctor my past medical and health history including any serious problems, injuries, pregnancy or drug use. I certify that I have not omitted or concealed any significant facts regarding my past or present health.

I agree to cooperate completely with the recommendations of the doctor while I am under his care, realizing that any lack of the same could result in a less than optimum result.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS, WORDS AND EXPLANATIONS WITHIN THE ABOVE CONSENT TO THE OPERATION PROPOSED. I FURTHER CERTIFY THAT I HAVE READ AND UNDERSTAND THE POST OPERATIVE INSTRUCTION SHEET THAT HAS BEEN PROVIDED TO ME.

_____ _____

Patient's First and Last Name Guardian's First and Last Name

_____ _____

Patient/Guardian Signature Date