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Extraction: Informed Consent

- Severe periodontal disease
- Irreversible damage to the nerve tissue inside the tooth
- Failed endodontic therapy
- Extreme fracture or decay of the tooth surface
- Improper positioning of the tooth or for orthodontic purposes

I have been informed of the reason for extraction of tooth #_____ and have been explained what to expect during this procedure. I understand that dental radiographs will be required prior to this extraction, and possibly during this procedure. I understand that I will require an anesthetic and that sutures maybe necessary.

I have been given and understand the post-operative instructions. I also understand that if I have been given an antibiotic medication, that I am to take it until the entire prescription is completely finished.

If I have been prescribed a pain medication, I will take it only necessary. If the pain medication contains a narcotic such as operating machinery or driving a motor vehicle will be dange could cause harm to myself or others.

I expect bleeding from the extraction site for the first 24 h

If I prefer, I can request that the extraction be done by an surgeon.

SOME COMPLICATIONS OF ROUTINE EXTRACTIONS INCLUDE (BUT ARE NOT LIMITED TO)

- Fracture of adjacent teeth or restorations
- Post-operative pain slight, moderate, or severe and lasting from hours to days
- Swelling at and around the extraction site
- Separated root tips or fragments, separated bone fragments
- Temporary or permanent nerve damage to the area resulting i numbness
- Incomplete healing resulting in severe pain (dry socket)
- Fracture of the surrounding bone

IF YOU HAVE ANY QUESTIONS ABOUT THE REASON FOR THIS EXTRACTION, PLEASE FEEL FREE TO ASK.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I HAVE NO FURTHER QUESTIONS ABOUT THE EXRACTION OF TOOTH #_____.

I GIV E MY PERMISSION TO HAVE THE TOOTH EXTRACTED.

Signature of Patient _____ Date _____

Signature of Parent, Guardian or Personal Representative _____ Date _____

Relationship to Patient _____