SURGICAL EXTRACTION CONSENT FORM

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All the benefits and risks of surgical tooth removal have been explained to me. I understand that surgical extraction may be necessary. I understand and accept the treatment which was recommended for me. I further understand that there may be some unwanted complications, some of which are listed below.

No guarantees have been given or implied. I understand that an impacted tooth may have begun to erupt in the wrong direction and may be blocked from erupting fully by bone and adjacent teeth. I understand allowing the impacted tooth/teeth to remain may result in infection and/or cyst formation which may destroy bone, damage the roots of adjacent teeth from pressure of the unfavourably angled tooth/teeth: and/or create a food trap which may result in decay.

Alternate treatment(s) and the option of no treatment have been explained to me. I understand the risk of not having the extractions performed, regardless of whether the tooth/teeth are impacted, partially impacted or not impacted at all, include, but are not limited to: Infection, swelling, pain, periodontal disease, malocclusion and systemic disease.

All of my questions have been addressed and proposed fees have been explained to me.

Treatment risks/unwanted consequences may be, but are not limited to:

1. Reaction to medications/anaesthetic
2. Temporary or permanent numbness or tingling of the lip, chin, tongue or other areas
3. Post-surgery bleeding
4. Post-surgery infection
5. Post-surgery tissue swelling
6. Root fragments may break which may be left in the jaw
7. Sinus involvement when upper teeth are removed, which may require additional treatment.
8. Jaw or alveolar bone may fracture during tooth removal, which may require additional treatmen
9. Healing may be delayed and may require additional treatments such as for a dry socket
10. Sensitivity/pain
11. Damage to adjacent teeth or restorations

The duration of my treatment, along with the number of appointments required is decided by the dentist at my initial consultation. I am aware that the number of appointments and their times may change during the treatment, at the discretion of the dentist. Whilst we aim to finish your treatment as soon as possible, our utmost consideration is your dental health. Unexpected risks or complications not discussed may occur. Unforeseen conditions may be revealed, requiring the performance of additional procedures and I authorize such procedures to be performed.

I have read and understand the above information and the information given to me verbally. By my signature below, I consent to the treatment described in this document. I also confirm I have received all pre- and post-surgery information.

Please note that minors (patients under the age of 18) must be accompanied by a parent/guardian at all times in the surgery. Under no circumstances are minors to be left unattended during treatment.

Signed ..................................

Date .....................................