Hidden Valley Dentistry

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Informed Consent for Dental Extractions

Patient Name: ___________________________________ Date: ___________ Tooth #: ________

I understand that there may be alternatives to the extraction of teeth. After considering the various options, I have chosen extraction. I understand that there are various normal complications that can occur despite all efforts to the contrary as a result of the extraction(s) which include, but are not limited to:

- Allergic reaction to medications or anesthetics used during the extraction process
- Pain, swelling, infection, bruising, and/or bleeding
- Stiffness of the jaw joint and/or the adjoining or nearby muscles
- Numbness- There is a possibility of injury to the nerves of the face or tissues of the oral cavity during the administration of anesthetics during the extraction, which may cause a numbness of the lips, tongue, tissues of the mouth and/or facial tissues. This numbness is most often temporary, but in rare cases can be permanent.
- Fracture of the root tips, which may also result in the root tips being left in place or the displacement of the root tip into the sinuses and/or nearby spaces.
- Dry socket(s), aspiration and/or swallowing of foreign objects
- Damage to the adjacent teeth and/or restorations

I further understand that this procedure can also be performed by a specialist and request that this procedure be performed in this office by a general dentist.

The dental care and treatment to be performed has been explained to me sand I understand what is to be done and that there is no warranty or guarantee as to any result and/or cure. I may ask the attending dentist for a more complete explanation. **This is my consent for the extraction, anesthetic, and x-rays to be taken. I have read and understand the above information and have had all of my questions answered to my satisfaction and I agree to proceed with the recommended extractions.**

Patient Signature ____ **Date:** ____________

Doctor's Signature ____ **Date:** ____________

Witness' Signature ____ **Date:** ____________

Additional Extraction Treatment Consent

Patient Signature ____ **Date:** ____________

Doctor's Signature ____ **Date:** ____________

Witness' Signature ____ **Tooth #:** ____________

Patient Signature ____ **Date:** ____________

Doctor's Signature ____ **Date:** ____________

Witness' Signature ____ **Tooth #:** ____________

Patient Signature ____ **Date:** ____________

Doctor's Signature ____ **Date:** ____________

Witness' Signature ____ **Tooth #:** ____________

Patient Signature ____ **Date:** ____________

Doctor's Signature ____ **Date:** ____________

Witness' Signature ____ **Tooth #:** ____________