

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

I am being provided this information and consent form so I may better understand the treatment recommended for me. Before beginning, I want to be provided with enough information, in a way I can understand, to make a well-informed and confident decision regarding my proposed treatment.

I understand that I may ask any questions I wish, and that it is better to ask them before treatment begins than to wonder about it after treatment has started.

### NATURE OF ORAL SURGERY

It has been recommended that I have the following oral surgical procedure: \_\_\_\_\_

This recommendation is based on visual examination(s), on any radiographs, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and wants have also been taken into consideration. The oral surgical procedure is necessary because of:

- Pain     Infection     Periodontal (gum) disease     Decay     Broken Tooth/Teeth  
 Tooth is not restorable     Other \_\_\_\_\_

The intended benefit of oral surgery is to relieve my current symptoms and/or to permit me to continue with any additional treatment my dentist has proposed.

### ALTERNATIVES TO ORAL SURGERY

Depending on my diagnosis, there may or may not be an alternative to extraction that involves other types of dental care.

- Tooth # \_\_\_\_\_ can be restored/retained by: \_\_\_\_\_  
 Tooth # \_\_\_\_\_ cannot be restored. Extraction is the only reasonable treatment option.  
 Other: \_\_\_\_\_

I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including:

\_\_\_\_\_  
Patient's Initials

### RISKS OF ORAL SURGERY

I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure, including extractions. I understand that during and following treatment I may experience pain or discomfort, bleeding, swelling, bruising and stiff jaws, all of which can last for several days. I understand that it is possible for an infection to occur in the extraction site and that I may need antibiotics and/or other procedures to treat the infection. I understand that less common complications include: dry socket (lost blood clot); loss or loosening of dental restorations; loss or injury to adjacent teeth and soft tissues; jaw fractures; sinus exposure (upper teeth); swallowing or aspiration of teeth and restorations.

I understand that small root fragments may break off from the tooth being extracted. Depending on their size and position, they may either be left to remain in the jaw or may require additional surgery for removal.

I understand that during surgery it may be impossible to avoid touching, moving, stretching or injuring the nerves in my jaw that control sensations and function in my lips, tongue, chin, teeth and mouth. This may result in nerve disturbances such as temporary or permanent numbness, itching, burning or tingling of the lip, tongue, chin, teeth and/or mouth tissues.

I understand that extracting the tooth may not relieve my symptoms and that complications can occur. Other treatment or procedures may be necessary.

**RISKS OF ORAL SURGERY (continued)**

I understand that I will be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

Other foreseeable risks not stated above include: \_\_\_\_\_

**ACKNOWLEDGMENT**

I have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs or other medications I am currently taking, as wells as those to which I am allergic. I will follow all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

I realize that in spite of the possible complications and risks, my recommended oral surgical treatment is necessary. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the treatment.

I, \_\_\_\_\_, have received information about the proposed treatment. I have discussed my treatment with Dr. Dillner and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options and the risks of the recommended treatment.

**I wish to proceed with the recommended treatment.**

I understand this treatment can also be performed by an oral surgeon.

\_\_\_\_\_  
Patient's Initials

I understand the risks and elect to have this procedure done by Dr. Dillner.

I understand that if any unexpected difficulties occur during treatment, I may be referred to an oral surgeon for further care of this tooth.

\_\_\_\_\_  
Patient or Guardian Signature Date

\_\_\_\_\_  
Treating Dentist Signature Date

\_\_\_\_\_  
Witness Signature Date