Serenity Dental

WEEPING WATER DENTAL

Discussion and Consent for Extraction

Patient's Name: _____
Name

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 I may ASK QUESTIONS I WISH, and it is better to ask them before treatment begins that to wonder about it after treatment has started.

Nature of Extraction

It is recommended that I have the following tooth (teeth) extracted: _____
Extraction involves the complete removal of a tooth from my mouth. Some extractions may require cutting into the gums and removing support bone and/or cutting into sections prior to removal.

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

☐ Pain ☐ Infection ☐ Periodontal (gum) Disease ☐ Decay ☐ Broken tooth/teeth
☐ Tooth is not restorable ☐ Other _____

The unintended benefit of extraction is to relieve my current symptoms and/or to permit me to continue with my additional treatment my dentist has proposed.

Alternatives to Extraction

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

☐ Tooth/teeth # _____ CAN be restored/retained by:
☐ Root canal therapy ☐ Filling ☐ Gum treatment ☐ Other _____
☐ Tooth/teeth # _____ CANNOT be restored. Extraction is the only reasonable treatment option.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including _____
(Patient initial)

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Risks of Extraction

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 jaw, all of which can last 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 loosing 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 the 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 tissue.

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

I understand that I will be given a local anesthetic injection and that in rare instances patients have an allergic reaction to 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 or sore from holding my mouth open during the treatment. Other foreseeable risks not stated above include:

I have had an opportunity to ask questions about these risks and any other risks I have heard about or thought about. _____

Patient initials

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Acknowledgement

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

I realize that in spite of the possible complications and risks, my recommended extractions/surgery/ treatment is necessary.

I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I, _____, have received information about the above proposed treatment. I have discussed my treatment with Dr. Neumann or Dr. Dabbert 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. _____ (Patient initial) I understand that this procedure can also be performed by an oral surgeon (a dental specialist). I understand the risks and elect to have this procedure done by Dr. Neumann or Dr. Dabbert. I understand that if any unexpected difficulties occur during treatment, I may be referred to an oral surgeon for further care.

Signed _____ Date _____
Patient or Guardian

Signed _____ Date _____
Treatment Dentist

Signed _____ Date _____
Witness

Pre-Op BP _____/_____ Pulse _____
Post-Op BP _____/_____ Pulse _____