

Date: _____

Patient: _____

Date of Birth: _____

I hereby authorize Dr. _____ and his/her associates to perform the extraction of the following tooth/teeth:

Dr. _____ has fully explained the benefits, risks, and prognosis of the proposed treatment including possible complications, as well as not getting the proposed treatment. They include, but are not limited to:

- Post-operative swelling, pain or bruising.
- Prolonged or heavy bleeding.
- Dry socket.
- Damage or loosening of adjacent teeth or fillings.
- Post-operative infection.
- Limited mouth opening and Jaw point (TMJ) discomfort especially if there are existing joint problems (TMD).
- Root fragments may fracture and possibly be left in my jaw, depending on the professional judgement of Dr. _____ to avoid extensive surgery or other complications.
- Jaw fracture or sinus involvement.
- Nerve injury resulting in temporary or permanent numbness, tingling of the gums, tongue, lip, cheek, or chin.

Dr. _____ also discussed other treatment options and alternatives:

I understand the risks associated with no treatment include, but are not limited to:

- Pain and infection.
- Spread of infection.
- Loss of bone.
- Complicated surgery if delayed.
- Possible cyst formation.

I understand that during the course of treatment, unforeseen conditions may arise and may necessitate further treatment; therefore, I consent to the performance of additional procedures that Dr. _____ consider necessary to complete the surgical procedure.

Patient Consent:

- I understand that during the course of treatment, unforeseen conditions may arise and may necessitate further procedures and / or deviation from the initial treatment plan, therefore I consent to the performance of additional procedures that Dr. _____ consider necessary to complete the treatment plan for my benefit.
- I understand that due to the nature of any dental treatment, there are no guarantees/warranties.
- All of my questions have been answered to my satisfaction.
- I understand my financial obligations, and that I am responsible for all fees regardless of insurance coverage, unless prior arrangements have been made.

I confirm that I have read and understand the above. I hereby consent to the proposed treatment plan.

Patient/Legal Guardian Name: _____
Patient/Legal Guardian Signature: _____
Interpreter (if needed): _____
Witness: _____

Dentist Certification:

I certify that I have explained the above proposed treatment including risks, benefits, alternative treatment options, as well as the consequences of no treatment. I have answered all the patient's questions to her/his satisfaction and believe that the patient fully understands what I have explained.

Dentist: _____
Date: _____