

INFORMATIONAL USE ONLY

INFORMED CONSENT FOR EXTRACTION

I understand that there may be alternatives to the extraction of teeth and after the doctor's explanation, I have chosen extraction. 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
- Pain, swelling, infection, bruising, bleeding
- Stiffness of the nearby muscles
- Numbness
- Root tips may fracture and be left in place or could be displaced into the sinuses and/or spaces nearby
- Dry sockets, aspiration and/or swallowing of foreign objects
- Damage to adjacent teeth and/or restorations

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

The dental care and treatment to be performed has been explained to me and 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, anesthetics, and x-rays to be taken.

I have read and understand the above and have had all my questions answered to my satisfaction and I agree to proceed with the recommended extractions(s).

Date

Signature