Bright Smiles Dentistry

Informed Consent for Oral Surgery

_____

Patient's Name Date

Please read the following and Initial where indicated. If you have any questions, please ask your doctor BEFORE initialing.

Your planned procedure _____

Alternative treatment _____

Oral Surgery involves procedures (Extractions, Alveoplasty "Bone Reshaping", etc), which may be simple or more complex. Any of the following may be associated with these procedure; you may experience some of these, none of these, or other complications:

_____ Pain, discomfort,bleeding,swelling,bruising,and stiff jaws "Trismus", all of which may last several days.
_____ Infection near the extraction site that may require antibiotics and/or other procedures.
_____ Dry socket "delayed healing", injury to adjacent teeth and tissues, jaw fractures, sinus exposure or a piece of tooth pushed into sinus, loss of dental restorations, swallowing or aspiration of teeth and restorations. Any of these occurrences may require additional treatment.
_____ Numbness, pain, or changed feeling in the teeth, gums, lip, chin and/or tongue (including possible loss of taste). Usually these resolve on their own but in rare cases they can be permanent.
_____ Fragments of tooth/root tips can break off from the Extracted tooth and either be left to remain in the jaw OR may require additional surgery for removal. Additionally, sharp ridges or bone splinters may form at the extraction site needing another surgery to smooth or remove.
_____ With the Extraction of a tooth you can often experience changes in the bite and added stress to remaining teeth; therefore it is usually recommended to replace extracted teeth. Your dentist has recommended_____. NOT recommended _____ that you plan to replace this tooth in the near future to minimize these effects.

The doctor may find a different condition than expected and may feel that a different surgery or more surgery needs to be done. If needed, the doctor may refer you to another doctor such as an (Oral Surgeon) for further evaluation/treatment.

I have provided the doctor with truthful and complete Medical History information, including current medications and health status, and I have notified the doctor if I am pregnant. All of my questions have been answered prior to signing this form.

_____ _____

Patient/Parent/Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date

Additional Extraction Consents:

			(Circle One)		
			Tooth restorable?	**YES**	**NO**
Doctor's Signature	Tooth #	Date	Recommend Replacing?	**YES**	**NO**
			Tooth restorable?	**YES**	**NO**
Doctor's Signature	Tooth #	Date	Recommend Replacing?	**YES**	**NO**