INFORMED CONSENT

Tooth Extraction

Including surgical extraction and wisdom teeth (third molars)

Please read this form carefully and ask us about anything that is unclear before you sign.

PATIENT NAME _____ DATE OF BIRTH _____

TREATING DOCTOR _____ DATE OF PROCEDURE _____

1 Recommended Treatment

I give my consent to the treating doctor named above, and to the dental team working under the doctor's direction, to perform the following procedure(s) on me or my dependent (the "Recommended Treatment"):

- ☐ Simple (non-surgical) tooth extraction
- ☐ Surgical extraction — may involve a gum incision, removal of bone, and/or sectioning of the tooth
- ☐ Removal of impacted tooth/teeth, including third molars (wisdom teeth)
- ☐ Other: _____

Tooth number(s) / area(s): _____

Reason for treatment: _____

I also consent to any additional procedure(s) the doctor considers necessary for my well-being based on findings made during the course of the Recommended Treatment (for example, smoothing of bone or placing sutures), and to the administration of local anesthesia. If sedation is planned, I will sign a separate sedation consent. The nature and purpose of the Recommended Treatment have been explained to me, and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed.

2 Purpose and Expected Benefits

Extraction is recommended to remove a tooth that is decayed, infected, fractured, impacted, or otherwise cannot be restored or kept healthy. Expected benefits may include relief or prevention of pain and infection, protection of neighboring teeth and bone, and preparing the mouth for further treatment such as orthodontics or tooth replacement. Individual results vary and cannot be guaranteed.

3 Treatment Alternatives

Alternative methods of treatment have been explained to me, including the following (doctor to check those discussed):

- ☐ **No treatment** — continued or worsening pain, infection, swelling, cyst formation, and damage to neighboring teeth or bone may occur
- ☐ **Monitoring** with periodic examinations and X-rays (may be appropriate for some teeth that are not causing problems)
- ☐ **Root canal treatment and restoration**, if the tooth can be saved
- ☐ **Coronectomy** — removing only the crown of a lower wisdom tooth and leaving the roots, which may lower the risk of nerve injury in selected cases
- ☐ **Referral** to an oral and maxillofacial surgeon or other specialist
- ☐ Other:_____

Having considered these alternatives, I wish to proceed with the Recommended Treatment described above.

4 Risks and Potential Complications

I understand that there are risks and potential complications associated with the administration of medications, including anesthesia, and with performance of the Recommended Treatment. These include, but are not limited to, the following:

GENERAL RISKS

1. **Drug reactions and side effects.** Including allergic reactions to medications, anesthetics, or antibiotics.
2. **Pain, bleeding, and infection.** Post-operative pain, bleeding, oozing, and soft-tissue and/or bone infection. In rare cases an infection can spread to the face, neck, or other areas and require urgent treatment.
3. **Swelling and stiffness.** Bruising and/or swelling, and restricted mouth opening for several days or weeks, or, rarely, longer.
4. **Delayed healing and dry socket.** Healing may be slower than expected, including “dry socket” (loss of the blood clot from the socket, causing pain), which requires additional post-operative care.
5. **Health and lifestyle factors.** Smoking or vaping, nicotine use, uncontrolled diabetes, a weakened immune system, and certain other conditions or medications increase the risk of infection, delayed healing, and treatment failure.
6. **Medications and prior radiation.** If I take medications that affect bone (such as bisphosphonates or denosumab) or have had radiation therapy to the head or neck for tumors/cancer, I am at higher risk for poor bone healing or bone death (osteonecrosis) that may never completely resolve and may require surgery or other treatment.

RISKS SPECIFIC TO EXTRACTION

7. **Bone loss.** Loss or removal of bone during tooth extraction, and sharp bone edges that may need later smoothing.
8. **Damage to neighboring teeth.** Damage to, or fracture of, adjacent teeth, fillings, crowns, or other restorations.

9. **Broken root tips.** Root tips may break during surgery. These may be left in the bone to avoid more aggressive surgery. However, more aggressive surgery may be needed, and I may be referred for this procedure.
10. **Sinus involvement.** Removal of upper back teeth may involve the sinus, including an opening between the mouth and sinus or displacement of a root or tooth fragment into the sinus, which may require additional treatment or surgical repair at a later date.
11. **Nerve injury.** Removal of lower teeth, particularly wisdom teeth, may injure the nerves of the lower jaw and tongue, resulting in temporary or permanent tingling, numbness, or pain of the lower lip, chin, tongue, or other surrounding structures, with possible alteration or loss of taste.
12. **Soft-tissue injury.** Bruising, stretching, cracking, or burns of the lips, cheeks, tongue, or corners of the mouth from instruments.
13. **Jaw fracture.** A fracture of the jaw is rare but may require additional treatment.
14. **Jaw joint (TMJ) problems.** Pain and/or limited movement of the jaw joint, either temporary or permanent, which may require further treatment.
15. **Swallowing or inhaling.** A tooth, tooth fragment, instrument, or small implant component may be swallowed or inhaled and may require retrieval.
16. **If a coronectomy is performed.** Remaining roots may move, become infected, or erupt over time, and a second procedure may be needed to remove them.
17. **Shifting of teeth.** Neighboring and opposing teeth may shift, and my bite may change, if a missing tooth is not replaced.
18. **Local anesthesia effects.** As a result of the injection or use of local anesthesia, there may be swelling, jaw muscle tenderness, or numbness, tingling, or pain of the tongue, lips, teeth, jaws, and/or facial tissues, and altered or lost taste. This is typically temporary but, in rare instances, may be permanent.

5 After Treatment and My Responsibilities

- I will follow all written and verbal post-operative instructions, including medications, diet, rest, and oral hygiene.
- I will avoid smoking, vaping, alcohol, drinking through a straw, and forceful rinsing or spitting for as long as the doctor advises, because these can cause dry socket and delay healing.
- I will take care not to bite or chew my lips, cheeks, or tongue while they are numb.
- I will attend my scheduled follow-up appointments.
- I will contact the office promptly — or go to the nearest emergency room if I cannot reach the office — for bleeding that does not stop with firm pressure, fever, severe or worsening pain, spreading swelling, pus, or any difficulty breathing or swallowing.
- If I receive sedation, I will also follow the separate pre- and post-sedation instructions.

6 Photographs and Records (Optional)

My care may be documented with photographs, X-rays, 3D scans, and clinical notes, which become part of my dental record. In addition, I may choose whether my records can be used for professional education, case presentation, or publication:

☐ I **agree** to the use of my records for education and professional case presentation, with all identifying information removed (no name, date of birth, or other identifiers).

☐ I **do not agree**; my records may be used only for my own care and the operation of this practice.

My choice will not affect my care. I will be asked for separate written permission before any image showing my face or other identifying features is published.

7 Patient Acknowledgment

By signing below, I confirm that:

- The nature and purpose of the Recommended Treatment, its expected benefits and risks, and the alternatives — including no treatment — have been explained to me in terms I understand.
- I have had the opportunity to ask questions, and they have been answered to my satisfaction.
- The health history, medication, and allergy information I have given this office is complete and accurate, and I will report any change before treatment.
- I understand that the risks listed in this form are not a complete list, that no guarantee has been made about the result, and that additional or different treatment may be needed.
- I understand that I may ask questions, or withdraw my consent, at any time before treatment begins.
- I have been offered a copy of this signed form.

I consent to the Recommended Treatment described in this form.

8 Signatures

☐ Interpreter or language assistance used — name / ID:_____

_____ _____

Patient / parent / legal guardian signature | Date and time

_____ _____

Printed name | Relationship to patient (if signer is not the patient)

_____ _____

Witness signature | Witness printed name

Doctor's statement. I have discussed the nature, purpose, benefits, risks, and alternatives of the Recommended Treatment with the patient (or the patient's legal representative), have answered their questions, and believe they understand and consent.

_____ _____

Treating doctor signature | Date and time