



## Informed consent for tooth extraction

Date

Patient name

I request that Dr.

extract tooth/teeth #

The Doctor has not recommended this treatment, however I insist to have it done and take full responsibility for my decision;

Extraction involves the complete removal of a tooth from the mouth. Some extractions require cutting into the gums and removing bone and/or cutting the tooth into sections prior to removal. The intended **benefit** of this treatment is to relieve my current symptoms and/or permit further planned treatment. The prognosis for this procedure is Good.

I have been informed of the following possible **alternative treatments**, and the costs risks & benefits of each: No treatment, Root Canal therapy, Filling, Crown, Gum treatment.

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 of discomfort, bleeding, swelling, bruising, and stiff jaws, all of which may last for days. Complications of therapy may include infection, dry socket, loss of fillings, injury to other teeth or soft tissues, jaw fracture, sinus exposure, or swallowing or aspiration of debris.

I understand that small root fragments may break off from the tooth being extracted, and that these fragments may be left 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 tissues.

I understand that I will be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand the injection areas may be uncomfortable following treatment, and that my jaw may be stiff and sore from holding my mouth open during treatment.

I have provided complete and accurate medical and personal history, including current medications, prescription and non-prescription, which I take, and any known drug allergies. I will follow all instructions as explained and directed to me, and will permit recommended diagnostic procedures, including X-rays.

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

I have been given the opportunity to ask questions regarding the benefit, risks, and alternatives of the procedure and have received satisfactory answers to all my questions.

I understand that this procedure can also be performed by a dental specialist, and that I may be referred to a specialist if unexpected difficulties occur.

I wish to proceed with treatment by Dr. Agafontsev.

Signed: \_

\_\_(Patient or Guardian)

Signed: \_

\_\_(Witness)