Informed Consent for Dental Surgery

Procedure: Extraction (removal) of teeth: _____

Alternatives to Surgery: Risks to my health if these teeth are not removed include, but are not limited to:

1. Infection
2. Cyst or tumor formation
3. Periodontal (gum) disease
4. Increased risk of complications if removal is required at a later date.

Possible complications which have been discussed with me include, but are not limited to:

1. Injury to the nerves of the lower lip and tongue causing numbness, which could possibly be permanent.
2. Bleeding and/or bruising which may be prolonged
3. Dry socket
4. Involvement of the sinus above the teeth
5. Infection
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and increased risk of complications.
7. Injury to adjacent teeth or fillings
8. Unusual reaction to medications given or prescribed.
9. _____

I understand that a perfect result can not be guaranteed. If any unforeseen conditions arise during the procedure, I request and authorize the doctor to do whatever he deems advisable to correct the condition.

I agree to co-operate with Dr. Miller/Dr. Goodman and will follow post-operative instructions to the best of my ability for my own comfort and safety. I have had the opportunity to ask questions concerning these procedures.

_____ _____

Patient Name Date

_____ _____

Parent or Guardian Witness