

The purpose of this consent form is to inform you of the risks that may occur during the extraction of teeth, and to confirm that we have discussed all treatment alternatives to your satisfaction.

Risks during Extraction of Teeth: Included, but not limited to, are the complications resulting from the use of dental instruments, analgesics (pain killers), anesthetics, and injections. These complications include pain, infection, swelling, bleeding, sensitivity, and numbness and/or tingling sensation (paresthesia) in the lip, tongue, chin, gums, cheeks, and teeth, which can last an indefinite period of time. Other complications include thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (the natural way the patient's teeth fit together), muscle cramps and spasms, jaw pain, loosening of teeth, injury to other soft tissues, damage to adjacent teeth and restorations, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, itching, bruising, delayed healing, perforation into the sinus, spread of infection, dislodging of the blood clot causing dry socket, fractured jaw, and further treatment by a specialist or even hospitalization if complications arise during or following treatment.

Other Treatment Options: All of the alternative forms of treatment have been explained to my satisfaction. This includes no treatment, delaying treatment, and referral to a specialist for their opinion and/or treatment. Treatment will be done in a manner to minimize or avoid risks as success cannot be guaranteed.

I also authorize the operating dentist and assistants to perform any other procedures they may deem necessary in attempting to improve the condition, or treat unhealthy or unforeseen conditions that may be encountered during the operation. I know that the practice of dentistry and surgery is not an exact science and, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have herein requested and authorized.

Consent for Treatment: I the undersigned, being the patient or responsible party for the patient, understand the aforementioned risks and treatment options. I authorize the extractions deemed to be advisable in the opinion of the dentist on the following teeth: _____

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THERIN REFERRED TO ME WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature _____ Date _____

Risk of Medication Related Osteonecrosis of the Jaw (MRONJ): I am initialing this section of the consent because the patient is taking or has taken medication known to cause osteonecrosis of the jaw. The risks, benefits, and alternatives have been explained to my full satisfaction. I understand that if the patient were to develop MRONJ, the patient would need to be seen by an oral and maxillofacial surgeon for treatment. _____