

Informed Consent for Extractions

Patient Name: _____ Date of Birth: _____

Procedure: _____

- _____ 1. **I understand** that following treatment I may experience **bleeding, pain, swelling, and discomfort** for several days, which may be treated with pain medication. It is possible **infection** can follow extraction and must be treated with antibiotics or other procedures. I will contact the office immediately if symptoms persist or worsen.
- _____ 2. **I understand** that I will receive a **local anesthetic and/or other medication**. In rare instances patients have a reaction to the anesthetic, which may require emergency medical attention, or find it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. Depending on the anesthesia and medication administered, I may need a **designated driver to take me home**. Rarely, temporary or permanent nerve injury can result from an injection.
- _____ 3. **I understand** that all **medication** have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell Dr. Lehrian/Dr. Palo and staff of all medications that I am taking which are: _____
- _____ 4. **I understand** that holding my mouth open during treatment may temporarily leave leave my **jaw feeling stiff and sore** and may make it difficult for me to open wide for several days. However, this can occasionally be an indication of a further problem. **I must notify your office** If this or other concerns arise.
- _____ 5. **I understand** that the necessary blood clot that forms in the socket may disintegrate or dislodge. This painful condition, called **dry socket**, lasts a week or more and is treated by placing a Medicated dressing in the tooth socket to aid healing. To protect against developing dry socket I must not smoke, drink through a straw, rinse with water or mouthwash, chew food in that area, or disturb the socket in any way for 24 to 48 hours.
- _____ 6. **I understand** that the instruments used in extracting a tooth may **unavoidably chip or damage adjacent teeth**, which could require further treatment to restore their appearance or function.
- _____ 7. **I understand** that upper teeth have roots that may extend to the **sinuses**. Removing these teeth may temporarily leave a small opening into the sinuses. Antibiotics and additional treatment may be needed to prevent a sinus infection and help this opening to close.
- _____ 8. **I understand** that an extraction may cause a **fracture** in the surrounding bone. Occasionally, the tooth to be extracted may be fused to the surrounding bone. In both situations, additional treatment is necessary. **Bone fragments** called "spicules" may arise at the site following extraction and are generally easily removed

_____ **9. I understand** that the nerves that control sensations in my teeth, gums, tongue, lips and chin run through my jaw. Depending on the tooth to be extracted (particularly lower teeth or third molars), occasionally it may be *impossible* to avoid **touching, moving, stretching, bruising, cutting or severing a nerve**. This could change the normal sensations in any of these areas, causing itching, tingling or burning, or the loss of all sensation. These changes could last from several weeks to several months or in some cases, indefinitely.

_____ **10. I understand** that if **no treatment** is performed, I may continue to experience symptoms, which could include pain and/or infection, deterioration of the bone surrounding my teeth, changes to my bite, discomfort in my jaw joint, and possibly, the premature loss of other teeth, and alternative treatment has been discussed with Dr. Lehrian/Dr. Palo

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

_____ **I give consent for the above listed procedure as described by Dr. Lehrian/Dr. Palo.**

Patient Name

Date

I attest that I have discussed the risks, benefits, consequences, and alternative to extraction with this patient who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

Dr. John Lehrian, DMD
Dr. David Palo, DDS

Date

Witness' Signature

Date