ORAL SURGERY CONSENT FORM

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Date:_____

I, _____ agree to have tooth/teeth #_____ extracted.

I fully understand the POSSIBLE COMPLICATIONS ARE:

- Soreness, swelling, bruising, and restricted mouth opening during healing.
- Bleeding, usually controllable, but may require additional care.
- Infection, possibly requiring additional treatment.
- Dry socket – discomfort/pain a few days after extraction requiring further care.
- Damage to adjacent teeth or fillings.
- Sharp ridges or bone splinters which may require additional surgery to smooth area.
- Root fragments – Sometimes fine root tips break off and may be deliberately left in place to avoid damage to nearby vital structures such as nerves or sinus.
- Fracture of the jaw or smaller portions of bone that support teeth.
- Numbness – The nerve in the mandible (lower jaw) is sometimes at risk of being injured due to the proximity of tooth roots and/or anesthesia placement. The lip, chin, gums or tongue could feel numb for days, weeks, or very rarely, permanently.
- Sinus Involvement – A possible sinus infection or sinus opening may result due to the proximity of upper molar roots. This may require medication and/or later surgery to correct.

I understand the treating dental provider may discover other or different conditions that may require additional or different procedures from those planned. I authorize such procedures as a deemed necessary in my doctor's professional judgment to complete my surgery.

I have read this form and discussed my surgery with my treating dental provider, and all my questions have been answered satisfactorily. I consent to the planned surgery.

Patient Signature (Parent, if minor)_____

Witness:_____

Doctor:_____