CONSENT FOR EXTRACTION

I understand that there may be an alternative to extraction and I have chosen extraction. I understand there are various complications that can occur despite all efforts to the contrary and they include but are not limited to: allergic reaction to medications and anesthetics, pain, swelling, infection, bruising, bleeding, muscle stiffness, numbness or tingling, root tip fracture which could be left in place or displaced into the sinus or other spaces, dry sockets, aspiration or swallowing of foreign objects, damage to adjacent teeth and/or restorations, sinus involvement, jaw or alveolar fracture, temporomandibular joint (TMJ) problems.

I understand that some of the potential complications can be avoided by carefully following the Doctor's instructions. I understand that medication given during or after surgery may cause drowsiness and a lack of awareness and coordination which could be increased by the use of alcohol or other drugs. I have been advised not to operate any vehicle or hazardous devices while taking such medication and for at least 24 hours.

I understand that this procedure can also be performed by a specialist and I prefer that it be performed in this office by a general dentist. I have had all my questions answered to my satisfaction and I consent to the extraction of tooth/teeth number(s) _____

_____

with the use of local anesthesia. I understand this authorization and no guarantees have been made to me.

Patient Name_____ Date_____

Patient Signature _____

Witness Signature_____