Informed Consent: Oral Surgery

Extractions (Tooth Removal): Treatment risks and unwanted consequences may include, but are not limited to, temporary or permanent numbness or tingling of the lip, chin, tongue, or other areas; post-treatment bleeding, infection, or tissue swelling; broken root fragments, which could be left in the jaw; sinus involvement when upper teeth are removed, which may require additional treatment; and jaw or alveolar bone fracture during tooth removal, which may require additional treatment. Healing may be delayed, and the patient may require treatment for conditions such as a dry socket, sensitivity, and pain. Damage to adjacent teeth or restorations during tooth/teeth removal is possible.

Changes in Treatment Plan: During the course of treatment, procedures may need to be added, expanded, or changed if the dentist finds conditions that were not identified during examination and first observed during the course of treatment. The most common scenarios include the need for root canal therapy and more extensive restorative procedures, like crowns, bridges, or implants. Permission is hereby given to perform any additional or expanded dental services that the dentist determines to be necessary. Further, at the dentist's discretion, I may be referred to a specialist for further treatment, the cost of which may be my responsibility.

Drugs, Medications, and Sedation: Drugs, medications, or anesthesia/sedation can cause allergic and other reactions. Examples include, but are not limited to, swelling, redness, itching, vomiting, diarrhea, and numbness or tingling of the lip, gum, or tongue (which in rare cases may be permanent), as well as, in rare cases, anaphylactic shock. Since drugs, medications, or anesthesia/sedation also may cause drowsiness and impair coordination or awareness, patients should not operate a motor vehicle or hazardous device before achieving full recovery. I have informed the dentist of all drugs and medications I am taking or have taken within the last 30 days, as well as those that have been prescribed within the last six months but not taken, and of all allergies and sensitivities of which I am aware. I have been informed and understand that failure to take drugs or medications as prescribed by my dentist may result in continued or aggravated infection and pain, and potential resistance to effective treatment. I also understand that antibiotics can reduce the effectiveness of birth control pills.

I have discussed treatment alternatives, risks, outcomes, and costs with my dentist and have had all of my questions answered before making a decision. I understand that dentistry is not an exact science and that there are no guaranteed results. Unless otherwise provided by law, I understand that I am responsible for payment of all dental fees not paid in full by any insurance or other applicable coverage. Having had adequate time to reflect upon the alternatives, I consent to the treatment, subject to changes in treatment plan, as detailed above.

_____ _____

Patient Signature Date

_____ _____

Tooth Number(s) Witness

This sample document contains information that you may use or modify for your practice's needs. Your needs may vary based upon the laws in your state. This document does not constitute legal advice.