Vo Dentistry
Experience The Difference
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CONSENT FOR TOOTH EXTRACTIONS

Patient's Name: _____ Date: _____

I request that Dr._____ extract tooth/teeth#_____

The doctor has recommended this treatment because of:
□ Pain □ Infection □ Gum disease □ Decay □ Broken tooth □ Not restorable □ Other_____

I have been informed of the following possible **alternative treatments**, and the costs, risks & benefits of each:
□ No treatment □ Root canal therapy □ Filling □ Crown □ Gum treatment □ Other_____

_____ **I decline the alternative treatments**

The most foreseeable risks and consequences of this treatment are but not limited to: post surgical infection, swelling, bleeding, bruising, "dry socket" leading to delayed healing, possibility of disturbance of the jaw joint, leading to muscle spasm or clicking / popping, tearing a hole in the maxillary sinus, resulting in sinus congestion and possible need for surgical repair, and transient (on rare occasions permanent) numbness of the jaw, lip, tongue, chin or gums. Jaw fracture - while quite rare, it is possible in difficult or deeply impacted teeth. There might be other strange consequences that are so rare that they cannot be reasonably anticipated.

The most foreseeable risks and consequences of not having this treatment done are but not limited to: swelling, infection, spasm of jaw muscles making jaw opening impossible.

Are patient taking any medications for bone diseases (bisphosphonates)? □ Yes □ No
If yes, please list the medications: _____

I am allergic to the following antibiotics, drugs, or medicines:_____

_____ I realize that in spite of the possible complications and risks, this treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of this treatment or procedure.

_____ I have provided as accurate and complete a medical and personal history as possible. I will follow any and all postoperative instructions as explained to me and directed.

_____ I have had the opportunity to ask questions and receive answers about contemplated and alternative procedures, and the risks and potential complications prior to signing this form.

_____	_____	_____
Patient's (or Legal Guardian's) Signature	Doctor's Signature	Witness' Signature

Pre-op blood pressure: _____ ***Pre-op oral temperature (F):*** _____

Post-op blood pressure: _____