CONSENT FOR THE EXTRACTION OF IMPACTED LOWER THIRD MOLARS

I, (print name) _____, hereby authorize

Dr. (print name) _____ to extract the following impacted lower third molar (teeth):

_____

I have been informed of the need to have the tooth (teeth) removed.

The details of the procedure have been explained to me, and I fully understand them.

I have been told about the alternatives to the extractions, their risks and benefits.

I understand that following the extraction(s), there may be a period of numbness of the jaw, some swelling, bleeding, discoloration and possible discomfort.

I understand that because the position of the nerves in the area of the impaction(s) cannot be determined by x-rays, injury to the nerves may be unavoidable and may result in loss of sensation to the chin, lips, and tongue for a period of time. I have been told that although it is usual for the numbness to be temporary it may, on rare occasions, be permanent.

I understand additional complications, although rare, may occur.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the extractions, I agree to report them to the office as soon as possible. In case of an acute emergency, and in the event you cannot reach this office, or we have not returned your call in a reasonable amount of time, please proceed to the nearest emergency room for medical attention.

I have been told that the success of the surgery depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I have discussed all of the above with the doctor, and have had all my questions answered.

_____ Patient's Signature

_____ If a Minor, Signature of Parent Or Guardian

_____ Witness Signature

_____ Doctor's Signature

_____ Date

INFORMED CONSENT FOR
BONE PRESERVATION FOLLOWING TOOTH EXTRACTION

Patient's Name Date

If you have any questions, please ask your doctor BEFORE signing.

You have the right to be informed about your condition and the recommended treatment plan. This disclosure is meant to provide information to help you understand the possible risks and complications of treatment, so you may decide to give or withhold your consent.

1. The procedure necessary to treat the condition has been explained to me as ***BONE PRESERVATION FOLLOWING TOOTH EXTRACTION*** *I have been informed that following extraction of a tooth, the loss of jaw bone height and width may result in 40% to 60% loss of bone height and width within 2-3 years or sooner. I have been informed that it is important to maintain adequate width and height of the jaw bone following extraction to help ensure adequate volume of bone for future implant placement or a partial or full removable denture placement.*

2. I understand that there other forms of treatment or no treatment at all are choices. I have been in informed of the risks of those choices that have been presented to me.

3. My doctor has explained to me that there are certain risks and side effects associated with my proposed bone grafting treatment and, in this specific instance, they include, but are not limited to:

    a. Post-operative discomfort and swelling.

    b. Bleeding that may require additional treatment.

    c. Post-operative infection that my adversely affect the new bone graft and require additional treatment.

    d. Failure of the graft to integrate with natural bone.

    e. I understand that excessive smoking, alcohol, or sugar may effect gum healing and may limit the success of the procedure. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.

4. It is important to take any regular medications (high blood pressure, antibiotics, etc) or any medications provided by your dentist, using only a small sip of water.

5. It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted in paragraph 2 above. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.