

Oral Surgery Consent Form

I have been advised or have requested an extraction because of advanced bone loss, non-restorable decay, tooth fracture, continuing infection, food packing, cyst formation, declining root canal treatment to save tooth, non-restorability, or orthodontic needs. I have been informed of the following possible alternative treatments where clinically appropriate, and the costs risks & benefits of each: no treatment, root canal therapy, filling, a crown, or gum treatment. Some of these options may not apply.

Extraction involves the complete removal of a tooth from the mouth. Some extractions require elevating the gum tissue and exposing/removing bone and/or sectioning the tooth into smaller pieces prior to removal. The intended benefit of this treatment is to relieve my current symptoms and/or permit further planned treatment. Unsuccessful or difficult extractions may need to be referred to a specialist.

I understand that there may be alternatives to the extraction of teeth, including the option of no treatment. After the explanation given by the Dentist, I have chosen extraction. There are various normal complications that can occur despite all our efforts to the contrary as a result of the extraction(s) which include but are not limited to:

1. Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side. This may persist for several weeks, months, or in remote instances, permanently.
2. Postoperative infection requiring additional treatment such as a dry Socket. Smoking is a high-risk factor for dry socket.
3. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
4. Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint.
5. Injury to adjacent teeth and fillings. It is also not unusual for the tooth or teeth to fracture during extraction requiring further treatment and/or a portion of tooth to be left in the jawbone. Swallowing or aspiration of tooth/debris can happen.
6. In rare circumstances, cardiac arrest or breakage of the jaw.
7. Postoperative discomfort, swelling and bleeding that may necessitate several days of recuperation.
8. Necessary removal of bone during tooth extraction. Gum surgery and sutures (stitches) may also be needed which may dissolve over time by themselves or may need to return for removal. On occasions, we may have to leave an asymptomatic retained root in situ and retrieve at a later date and monitor over time. It may need a referral to a specialist to retrieve root.

9. A pre-operative x-ray is taken of the tooth to be extracted to check radiological landmarks, but an X-ray is a 2D image of a 3D tooth and certain features may not be clear or evident such as curved roots, sinus floor, bone density.

Unforeseen conditions may arise during the procedure that requires a different procedure than originally set forth. I therefore authorise the dentist and any associates to perform such procedures when, in their professional judgement, these are deemed necessary.

I have provided complete and accurate medical history and have eaten sufficiently prior to the procedure. I will follow all instructions as explained and directed to me, and will permit recommended diagnostic procedures, including X-rays.

I acknowledge that no guarantees have been made to me concerning the results of the procedure. I understand that the medications, drugs, anaesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and co-ordination. Women taking the Oral Contraceptive Pill must also be aware that any prescribed antibiotics may render this type of contraception ineffective. I also understand that I should not consume alcohol or smoke during the immediate post-operative period.

I may be advised not to work and not operate any vehicle, automobile or machinery while taking such medications and until fully recovered from their side effects. It has been explained to me and I understand that a perfect result is neither guaranteed nor warranted.

Informed consent: I have been given the opportunity to ask any questions regarding the nature, purpose, risks and alternatives of oral surgery and have received answers to my satisfaction. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorise the dentist and his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anaesthetics and/or medications.

I hereby authorise the dentist and any associates to perform the following procedure:

Patients Name (please print): Patient/Guardian Signature: Date:
