

DISCUSSION & INFORMED CONSENT FOR EXTRACTION(S)

Rev 03/2018

FACTS FOR CONSIDERATION

An extraction involves removing one or more teeth. Depending on their condition, extraction may require sectioning the teeth or trimming the gum or bone tissue. If any unexpected difficulties occur during treatment, I may refer you to an oral surgeon, who is a specialist in dental surgery.

Once the tooth is extracted, you will have a space that you may want to fill with a fixed or removable appliance. Replacement of missing teeth may be necessary to prevent the drifting of adjacent and/or opposing teeth to maintain function, or for cosmetic appearances. The options of a fixed or a removable appliance will be explained to you.

As in all surgical procedures, extractions are not without potential risks or complications. Since each person is unique and responds differently to surgery, the healing process may vary; no guarantees can be made.

Extracted teeth that are not replaced may lead to other teeth moving or drifting, creating spaces between the remaining teeth and making it difficult or impossible to replace or straighten them later. If left for a significant period of time, this drifting of teeth may lead to a “malocclusion” (bite) in which top and bottom teeth do not “fit” together as they once did.

BENEFITS OF EXTRACTION, NOT LIMITED TO THE FOLLOWING:

The proposed treatment is intended to help relieve your symptoms and may also enable you to proceed with further proposed treatment.

RISKS OF EXTRACTION, NOT LIMITED TO THE FOLLOWING:

I understand that following treatment I may experience bleeding, pain, swelling, and discomfort for several days, which may be treated with pain medication. It is possible infection can follow extraction and must be treated with antibiotics or other procedures. I will contact the office immediately if symptoms persist or worsen.

I understand that I may receive a topical and/or local anesthetic by injection and/or other medication(s). I understand that I may have loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) following injections. In rare instances, patients can have a strong and unpredictable reaction to the anesthetic, which may require emergency medical attention. The medication may affect my ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. *Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent*

16160 Monterey Road, Morgan Hill, CA 95037

☎ (408) 782-6568

☎ (888) 503-6560

✉ info@stDental.com

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nerve injury resulting in loss of feeling of the chin, lips, gums, tongue and partial loss of taste can result from an injection.

I understand that all medications in this office have the potential for accompanying risks, side effects and drug interactions. They can cause redness and swelling of the tissues, pain, itching, vomiting and/or anaphylactic shock. I attest that to my knowledge, I have given an accurate report of my physical and mental health history. I have also report any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I understand if I have taken or take medication for osteoporosis or cancer treatment that is a bisphosphate (such as but not limited to: Zometa, Aredia, Fosamax, Boniva, Acetonel), on rare occasions osteonecrosis (lack of blood to the jaw bone cells cause these cells to die) of the jaw may occur after an extraction and/or surgery; therefore, it is critical that I tell my dentist of all medications and vitamins I am currently taking, which I have done.

I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a most significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

I understand that the necessary blood clot that forms in the socket may disintegrate or dislodge. This painful condition, called dry socket, lasts a week or more and is treated by placing a medicated dressing in the tooth socket to aid healing. To protect against developing dry socket I must not smoke, drink through a straw, rinse with water or mouthwash, chew food in that area, or disturb the socket in any way for 24 to 48 hours. Smoking may adversely affect the extraction site healing and may cause "dry socket" (an infection of the bone of the socket walls). Smokers are at higher risk for "dry socket" and have more dry sockets than non-smokers.

I understand that the instruments used in extracting a tooth may unavoidably chip or damage adjacent teeth, which could require further treatment to restore their appearance or function.

I understand that upper teeth have roots that may extend close to the sinuses. Removing these teeth may temporarily leave a small opening into the sinuses. Antibiotics and additional treatment may be needed to prevent a sinus infection and help this opening to close. If such a complication occurs you may require additional treatment by physician or oral and maxillofacial surgeon.

I understand that an extraction may cause a fracture in the surrounding bone. Occasionally, the tooth to be

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extracted may be fused to the surrounding bone. In both situations, additional treatment is necessary. Bone fragments called “spicules” may arise at the site following extraction and are generally easily removed.

I understand that tooth fragments may be left in the extraction site following treatment due to the condition and position of the tooth/teeth. Generally, this causes no problems, but on rare occasions the fragments become infected and must be removed.

I understand that the nerves that control sensations in my teeth, gums, tongue, lips and chin run through my jaw. Depending on the tooth to be extracted (particularly lower teeth or third molars), occasionally it may be *impossible* to avoid touching, moving, stretching, bruising, cutting or severing a nerve. This could change the normal sensations in any of these areas, causing itching, tingling or burning, or the loss of all sensation including numbness of the chin, cheeks, lips, gums, or tongue, including loss of taste. These changes could last from several weeks to several months or in some cases, indefinitely.

CONSEQUENCES IF NO TREATMENT IS ADMINISTERED, NOT LIMITED TO THE FOLLOWING:

I understand that if no treatment is performed, I may continue to experience symptoms, which could include pain and/or infection, deterioration of the bone surrounding my teeth, changes to my bite, discomfort in my jaw joint, and possibly the premature loss of other teeth.

ALTERNATIVE TREATMENTS IF EXTRACTION IS NOT THE ONLY SOLUTION, NOT LIMITED TO THE FOLLOWING:

I understand that depending on my diagnosis, alternatives to extraction may exist which involve other disciplines in dentistry. I asked my dentist about them and their respective costs. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs.

FOR ALL PATIENTS

I understand that every reasonable effort will be made to ensure the success of my treatment. I further understand that each person and treatment situation is unique, and therefore, no guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The dentist will explain all changes.

I have been given the opportunity to ask questions about Extraction and believe that I have sufficient information to give my consent as noted below.

CONSENT

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I have been informed, both verbally and by the information provided on this form, of the risks and benefits and alternatives of the proposed treatment. I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition. I certify that I have read and understand the above information, that the explanations referred to are understood by me, that my questions have been answered. I authorize and direct the dentist to do whatever he/she deems necessary and advisable under the circumstances. I consent to have treatment performed. While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

If I am signing for a minor child, I attest that I am the parent and/or a legal guardian or I have the permission of the child's parent and/or a legal guardian (a separate authorization form is required). If I am signing for an adult, I attest that I am a legal guardian and am authorized to make medical and financial decision on patient's behalf.

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