DENTAL CLINIC
Consent for Tooth Extractions
and Other Oral Surgeries

I HEREBY GIVE PERMISSION TO __________________________________, D.D.S. TO PERFORM THE
FOLLOWING PROCEDURES AND SUCH ADDITIONAL PROCEDURES AS ARE CONSIDERED
NECESSARY ON THE BASIS OF FINDINGS DURING SAID PROCEDURE:

EXTRACTION OF TEETH #’S ___   ___   ___   ___   ___   ___   ___   ___   ___   ___   ___   ___   ___   ___   ___   ___
AND/OR _________________________________________________________________________________ ________

I CONSENT THIS TO BE DONE WITH LOCAL ANESTHESIA ONLY AND OTHER MEDICATIONS
LISTED BELOW.

A. ___________________________________________  B. ___________________________________________

THE FOLLOWING ALTERNATIVE METHODS HAVE BEEN EXPLAINED TO ME:

1.
2.
3.

THESE ALTERNATIVE METHODS OF TREATMENT ARE PRACTICAL AND POSSIBLE, BUT I DESIRE
THE TREATMENT MENTIONED IN PARAGRAPH #1. I ALSO CERTIFY THE REASONS WHY THE
ABOVE-NAMED PROCEDURES ABOVE CARRY CERTAIN COMMON INHERENT RISKS SUCH AS, BUT
NOT LIMITED TO:

A] DRUG REACTIONS AND SIDE EFFECTS
B] POST-OPERATIVE BLEEDING
C] POST OPERATIVE INFECTION OR BONE INFLAMMATION (DRY SOCKET).
D] NECESSARY REMOVAL OF BONE DURING TOOTH EXTRACTION.
E] POSSIBLE INVOLVEMENT OF THE SINUS OF THE UPPER JAW DURING REMOVAL OF UPPER
BACK TEETH REQUIRING POSSIBLE SURGERY FOR REPAIR AT A FUTURE DATE.
F] POSSIBLE INVOLVEMENT OF THE NERVE WITHIN THE LOWER JAW DURING REMOVAL OF
LOWER MOLAR TEETH, RESULTING IN USUALLY TEMPORARY BUT POSSIBLE PERMANENT
NUMBNESS AND/OR TINGLING IN THE LOWER LIP, RIGHT AND/OR LEFT SIDE.

I AM AWARE THE PRACTICE OF DENTISTRY AND ORAL MAXILLOFACIAL SURGERY IS NOT AN
EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS A
RESULT OF THE PROCEDURES AUTHORIZED ABOVE.

DATE __________________________ FIRST    LAST    MI (PLEASE PRINT) __________________________

_________________________ SIGNATURE OF PATIENT OR RESPONSIBLE PARTY __________________________

93-500.005