

CONSENT FORM FOR THE REMOVAL OF A PERMANENT TOOTH

ABOUT THE PROPOSED TREATMENT: **Tooth #** _____

Dr. Nielson has explained the benefits and risks of tooth removal to me. I understand that surgical extraction may be necessary. Surgical extraction is needed when the crown of a tooth fractures leaving the roots remaining in the jaw bone. Referral to a specialist (oral surgeon) has been offered.

TREATMENT RISKS/COMPLICATIONS ARE (BUT NOT LIMITED TO)

- **Root fragments may break; a small piece may be left in the jaw**
- **Jaw or alveolar bone may fracture during tooth removal**
- **Sinus perforation when upper teeth are removed**
- **Temporary or permanent numbness or tingling of the lip, chin, tongue**
- **Damage to adjacent teeth or restorations**
- **Dry socket**
- **Post treatment bleeding**
- **Post treatment pain, swelling, or infection**

CONSEQUENCES OF NOT PERFORMING TREATMENT

Persistent infection that can cause bone loss in the area, damage other teeth, cause severe pain, swelling, and spreading of the infection to other parts of the body.

ALTERNATIVES

Do nothing. In some cases the tooth can be saved with a dental restoration or root canal treatment.

ALL OF MY QUESTIONS HAVE BEEN ADDRESSED. NO GUARANTIES HAVE BEEN MADE OR IMPLIED. BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Patient's Signature & Date _____

Witness & Date _____