Dr. Tupman
Family Dentistry
Dr. Lowell Tupman BSc, DDS

CONSENT FOR EXTRACTION

Patient's Name _____Date of Birth_____

I am being provided with this information and consent form so I may better understand the treatment that has been recommended for me. Before beginning, I wish to be provided with enough information, in a way I can understand, so that I may make a well-informed decision regarding my proposed treatment.
I understand that **I may ask any questions I wish**, and that it's better to ask them before treatment begins than to wonder about it after treatment has started.

NATURE OF EXTRACTION

It has been recommended that I have the following tooth/teeth extracted;

Extraction involves the complete removal of a tooth from the mouth. Some extractions may require cutting into the gums and removing supporting bone and/or cutting the tooth into sections prior to removal.
This recommendation is based on visual examination, on any x-rays, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. My needs and desires have also been taken into consideration. The extraction is necessary because of:

Pain Infection Periodontal (gum) disease Decay Broken tooth/teeth
Tooth is not restorable other_____

ALTERNATIVES TO EXTRACTION

Depending on my diagnosis, there may or may not be an alternative to extraction that involves other types of dental care.

Tooth #_____ can be restored/retained by:
Root canal therapy Filling Crown Gum treatment other_____

Tooth # _____ cannot be restored. Extraction is the only reasonable treatment option.

_____
Patient's Initials

RISKS OF EXTRACTION

I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure, including extractions. I understand that during and following treatment, I may experience pain or discomfort, bleeding, swelling, bruising, and stiff jaw, all of which may last several days. I understand that it is possible for an infection to occur in the extraction site and that I may need antibiotics and/or other procedures to treat the infection. I understand that less common complications include dry socket (lost blood clot), loss or loosening of dental restorations, loss or injury to adjacent teeth and soft tissues, jaw fractures, sinus exposure (upper teeth), swallowing or aspiration of teeth and restorations.

I understand that small root fragments may break off from the tooth being extracted. Depending on their size and position, they may either be allowed to remain in the jaw or may require additional surgery for removal.
I understand that extracting the tooth may not relieve my symptoms and that complications may occur. Other treatment or procedures may be necessary.

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I understand that I will be given local anesthetic injection and that in rare situations, patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment, and that my jaw may be stiff and sore from holding my mouth open during treatment.

_____
Patient's Initials

ACKNOWLEDGMENT

I have provided as accurate and complete medical and personal histories to the best of my knowledge, including antibiotics, drugs, or other medications I am currently taking, as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the surgical procedure and/or results.

I, _____, have received information about the proposed treatment. I have discussed my treatment with Dr. Tupman/Dr. Durkot and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risk of refusing treatment.

I understand that this procedure can also be performed by an oral surgeon (specialist). I understand the risks and elect to have this procedure done by Dr. Tupman/Dr.Durkot. I understand that if any unexpected difficulties occur during treatment, I may be referred to an oral surgeon for further care.

Please review the following carefully and circle Yes or No:

Do you take Blood Thinners?	**Yes/No**
Do you currently, or have you ever, taken Bisphosphonate medications (for osteoporosis)?	**Yes/No**
Do you have any bleeding disorders (Do you bleed easily)?	**Yes/No**
Have you ever had radiation treatment of the head or neck?	**Yes/No**
Do you, or have you ever, taken anti-depressants (SSRI's)?	**Yes/No**

I wish to proceed with the recommended treatment.

Signed:_____ **Date:**_____
Patient, Parent or Guardian

Signed:_____ **Date:**_____
Treating Dentist

Signed:_____ **Date:**_____
Witness