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REMOVAL OF UPPER OR LOWER IMPACTED TOOTH/TEETH
INFORMED CONSENT

The purpose of this Informed Consent Form is to provide an opportunity for patients (and/or their parents or guardians) to understand and give permission for TREATMENT FOR REMOVAL OF IMPACTED TOOTH/TEETH. Each item should be checked off after the patient has the opportunity for discussion and questions.

_____ 1. I, THE UNDERSIGNED, CONSENT TO Dr._____, his/her partners, and/or associates performing on me the outlined treatment for Removal of Impacted Tooth/Teeth (*as outlined on the "Treatment Form" that has been provided to me*).

_____ 2. I accept and understand that this treatment for Removal of Impacted Tooth/Teeth consists of a surgical procedure that requires:

_____ a. Incision to reflect tissues (gums);
_____ b. Removal of bone for exposure of the impacted tooth;
_____ c. Cutting the tooth to facilitate removal;
_____ d. Wound closure with stitches; and/ or
_____ e. Sedation or General Anesthesia

_____ 3. I accept and understand that it is common for lower impacted tooth/teeth to develop in close proximity with nerves that pass through the jaws and gums; and accept and understand that this relationship may lead to pressure transmitted to the nerves during extraction, including pain before and after procedure.

_____ 4. I accept and understand that the treatment for Removal of Impacted Tooth/Teeth MAY BE followed by a degree of discomfort and swelling requiring five (5) to ten (10) days of recuperation.

_____ 5. *Each option has been fully explained to me with its' benefits, risks, pros, cons and approximate investment cost*. I accept and understand that there are *risks and limitations* to all procedures. For this treatment for Removal of Impacted Tooth/Teeth these risks and limitations include, but are not limited to:

_____ a. Temporary or permanent numb or altered sensation, which may occasionally occur, in the lower lip, chin, or tongue on the operated side.
_____ b. Postoperative bleeding.
_____ c. Injury to adjacent teeth and fillings.
_____ d. Post-operative infection requiring further treatment
_____ e. Possibility of small root fragments remaining in the jaws, when their removal would require extensive surgery.
_____ f. Fracture of jawbone.
_____ g. Soreness at corners of mouth.
_____ h. Opening of the sinus, a normal cavity in the jaw above the upper teeth.

_____ i. Stiffness of the jaws or jaw joint (in front of ear), preventing complete opening of the mouth

_____ j. Discoloration (black and blue of face and jaw).

_____ k. If intravenous medication is used, soreness at injection site or along the vein may develop, as well as some discoloration of the injection site.

_____ 6. I acknowledge that the alternatives to this treatment have been discussed with me and I understand these alternatives and the associated consequences of declining them.

_____ 7. I have had the opportunity to discuss the treatment for Removal of Impacted Tooth/Teeth, and have had an opportunity to ask questions, and am fully satisfied with the answers received.

_____ 8. If, during the procedure, a change in treatment is required to fulfill the complete treatment plan, I authorize the doctor and the operative team to make whatever change they deem in their professional judgment is necessary. I understand that I have the right to designate the individual who will make such a decision.

Patient's Signature (or Parent/Guardian):_____ Date: _____

Patient's (or Parent/Guardian's) Identification: _____

Witness' Name: _____ Witness' Signature: _____ Date:_____

Doctor's Signature: _____Date: _____