Brian Mitchell, D.D.S.

Inform Consent Tooth Extraction

I, ____, understand that the extraction of tooth/teeth number(s)________________________has been recommended by my dentist. I have had alternative treatment (if any) explained to me, as well as consequences of doing nothing about my current dental condition(s). I understand that non-treatment may result in but not limited to: infection, swelling, pain, periodontal disease, malocclusion (damage to the way the teeth fit together) and systemic disease.

I understand that there are risks associated with any surgical dental and anesthetic procedure(s). These include, but are not limited to:

- Post-operative infection
- Delayed healing (dry socket), necessitating frequent post-operative care
- Swelling, bruising, inflammation, and pain
- Damage to adjacent teeth and/or fillings
- Bleeding, possibly requiring further treatment
- Drug reactions and side effects
- Possibility of small fragment of root or bone being left in the jaw when its removal is not appropriate. Such fragments may work their way partially out of the tissue and need treatment at a later date
- Fracture or dislocation of the jaw
- Damage to nerves, resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or others areas

I understand the recommended treatment, the fee(s) involved, the risks of treatment, any alternatives and risks of those alternatives, including the consequences of doing nothing. I have had all of my questions answered, and have not been offered any guarantees.

Patient Signature____Date__________

Witness Signature____Date__________