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Family & Cosmetic Dentistry - 2511 *Broadmoor Blvd.* - *Monroe,* LA 71201 - 318·322·2013

INFORMED CONSENT FOR:

TOOTH EXTRACTION (Oral Surgery)

Patient Name: _____ Date: _____ Teeth: _____

To be sure of your understanding, you are being asked to sign this informed consent. This confirms that we have discussed the nature and purpose of your treatment and the risks associated therein. Please ask about anything you do not understand. **Performing a Surgical and/or Non-Surgical Extraction of a Tooth is permanent, irreversible, and requires local anesthesia.**

ALTERNATIVES TO SAVE A TOOTH RATHER THAN EXTRACT IT (including, but not limited to: fillings, root canals, implants, crowns, bridges) to the recommended treatment, including no treatment, have been explained to me, as have the advantages and disadvantages of each.

RISKS ASSOCIATED WITH THE RECOMMENDED TREATMENT:

I understand that dentistry is not an exact science and that complications may occur despite our best efforts. A list of possible risks known to be associated with oral surgery and associated anesthetics includes, but is not limited to:

- Swelling, discomfort, Infection, pain, and/or bruising that may necessitate staying home several days.
- Development of unrelated infections possibly requiring further treatment
- Dry Socket, delayed healing, retained instrument fragment(s) and/or breakage, Aspiration &/or swallowing of objects
- Bleeding which may require stopping the procedure or unexpected post-op bleeding
- Paresthesia (permanent or transient numbness of the cheeks, gums, teeth, lip, tongue, chin, face, loss of taste)
- Breakage of root(s) or retained root fragment(s) may be left if retrieval could cause more harm
- Loss/damage to adjacent teeth & bone, fillings and/or Crowns/bridges
- Sinus involvement with upper teeth
- Drug Allergic Reaction
- TMJ dysfunction, Fracture or breakage of jaw or worsening of TMJ condition
- Trismus (Jaw pain or difficulty opening mouth) & possible change in the bite
- Stretching or cracking of corners of mouth
- Failure of treatment to accomplish its goal
- Further surgery or treatment

Although rarely occurring, the dental treatment or anesthetic may possibly result in: Death, Brain Damage, Quadriplegia, Paraplegia, Loss of Organ(s), Loss of Organ(s) Functions, Loss of Function of Face, Arm(s), Leg(s), and disfiguring scars.

ACKNOWLEDGMENT:

I acknowledge that I have read the above information (or it has been read to me) and I understand it, including all the technical terms. I understand that the success of the treatment and the avoidance of complications depend to an extent upon my complying with the post-operative instructions that have been explained and given to me, compliance with drug prescriptions given, and my keeping the appointments for treatment or follow-up office visits scheduled or recommended. I also understand that I am to notify Dr. Eddleman immediately of any suspected complication(s), where further treatment may be discussed or administered. I have been given an opportunity to ask any questions about the proposed treatment or information on this form, and any I had were answered satisfactorily. By signing below, I give Dr. Eddleman and/or his staff my informed consent to perform the surgical procedure.

Patient Signature _____

Witness Signature _____