Woodstock General & Implant Dentistry
121 Route 375
Woodstock, NY 12498

(845) 679-3706
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Discussion and Consent for Extraction

I am being provided this information and consent form so I may better understand the treatment recommended for me. Before beginning, I want to be provided with enough information, in a way I can understand, to make a well informed and confident decision regarding my treatment.

I understand the I may ask any questions I wish, and that it is better to ask before the 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/ or cutting the the tooth into sections prior to removal.

This recommendation is based on visual examination(s), on x-rays, model, photos, and other diagnostic test taken, and on my doctor's knowledge of my medical and dental history. My needs and wants have also been taken into consideration.

The extraction is necessary because of:

- ☐ Pain
- ☐ Infection
- ☐ Periodontal (gum) disease
- ☐ Decay
- ☐ Broken Tooth/Teeth
- ☐ Tooth is Non-restorable
- ☐ Other_____

The intended benefit of extraction is to relieve my symptoms and/or permit me to continue with any additional treatment my dentist has proposed.

The prognosis, or chance of success, of this extraction is:

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My extraction(s) is (are) estimated to cost $

Expected visit(s) required to complete this treatment:

Alternatives to Extraction

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

The tooth CAN be retained/restored by:

☐ Root Canal therapy ☐ Filling ☐ Periodontal treatment

Other treatment (specify):

The tooth CANNOT be retained/restored. Extraction is the ony reasonalbe treatment option.

◯ Yes ◯ No

I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including:

☐ 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 could last for 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 inury to adjacent teeth and soft tissues, jaw fractures, sinus exposure (related to upper teeth only), 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 remain in the jaw or may require additional surgery for removal.

☐ I understand that during surgery it may be impossible to avoid touching, moving stretching, or injuring the nerves in my jaw that control sensations and function in my lips, tongue, chin, teeth, and mouth. This may result in nerve disturbances such as temporary numbness, itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissue.

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☐ I understand that extracting the tooth may not relieve my symptoms and that complications can occur. Other treatment or procedures may be necessary.

☐ I understand that I will be given a local anesthetic injection and that in rare instances patients have had allergic reaction to this anesthetic, and 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 the treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

Other foreseeable risks not stated above include:

☐ I have had the opportunity to ask questions about these risks and any other risks I have heard or thought about.

Acknowledgment

I have provided as accurate and complete a medical and professional history as possible, 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 diagnositc procedures, including x-rays.

I realize that in spite of the possible complications and risks, my recommended extraction/surgery treatment is necessary. I am aware the practice of dentistry and surgery are not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have received information about the proposed treatment. I have discussed my treatment with my dental provider and have been given the opportunity to ask questions and have had them fully answered. I undestand the nature of the recommended treatment, alternate options, and the risk of the recommened treatment.

◯ Yes ◯ No

I wish to proceed with the recommended treatment.

☐ I understand that this procedure can also be performed by an oral surgeon
I understand the risk and elect to have this procedure done by my dental provider.
I understand that if any unexpected difficulties occur during this treatment, I may be referred to an oral surgeon for futher care.

Response Dale: