Extraction Consent Form

Alternatives to the removal have been explained to me, and I authorize Charlotte Progressive Dentistry to remove the necessary teeth as indicated on my treatment plan. I have been made aware of which tooth/teeth are going to be extracted and that removal of teeth is an irreversible process. I understand there will be loss of bone around the extraction site and adjacent teeth, as well as, shrinkage of the gingival tissues. I understand there are risks involved and they include, but are not limited to: Pain; Swelling; Bruising; Stretching of the corners of the mouth; Infection requiring further treatment; Dry socket; Damage to adjacent teeth; Nerve injury resulting in numbness or altered sensation (parasthesia) in the teeth, gums, lips, tongue, and chin (sensation most often returns to normal, but may be permanent); Trismus (limited jaw opening); Bleeding; Sharp ridges or bone splinters (may require an additional procedure to remove them); Incomplete removal of the tooth; Sinus perforation; or Fracture of the jaw. I understand that I may need further treatment by a specialist (Oral Surgeon) if complications arise and the costs incurred will be my responsibility.

By signing this form, I understand that analgesics and other medications, including local anesthetics, can cause allergic reactions resulting in redness, swelling, nausea, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand that dentistry is not an exact science and therefore no guarantee or assurance has been made to me regarding the dental treatment I have authorized. I certify that I have read and fully understand the above authorization and informed consent I have had the opportunity to discuss and ask any questions regarding the dental treatment I will receive, and all questions have been answered to my satisfaction. I give my consent willingly to this procedure.

Patient Name

_____

Signature of patient, legal Guardian, or authorized representative

_____

Date _____