SKHDENTISTRY
519-745-1821

TREATMENT CONSENT FORM FOR EXTRACTION

What you are being asked to sign is a confirmation that we have discussed the nature and the purpose of dental treatment, the known risks associated with dental treatment, and the feasible treatment alternatives. You are also acknowledging that you have been given an opportunity to ask questions and all your questions have been answered in a satisfactory manner to your understanding. Please read this form carefully before signing it and ask about anything that you do not understand.

1. I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of surgery can be made due to the uniqueness of every individual clinical situation. In most instances, the outcome of treatment is most satisfactory.

2. I understand that Dr. Zigler has carefully examined my mouth and/or x-ray(s). Alternate procedures to extraction have been explained. (root canal treatment, no treatment) I have tried or considered these methods, but I desire an extraction.

3. We have discussed tooth replacement options and the potential outcome of not replacing the tooth to be extracted.

4. I have been informed of the possible risks and complications involved with surgery, drugs and anesthesia that include but are not limited to the following: pain, swelling, infection, discoloration, inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing and allergic reactions to drugs or medications prescribed. Numbness of the lip, tongue, chin, cheek, or teeth may also occur, for which the exact duration may not be determinable and may be irreversible.

5. I understand that in the event of one of the above complications another procedure may be required and I would endure these costs. This may include the repair of jaw fractures or any damage to existing restorations.

6. I understand that with any dental treatment, my teeth, gums, or bone can be damaged by bacteria and I must do my utmost to remove the bacterial plaque off all the surfaces of all my teeth every day.

7. I understand that excessive smoking, alcohol, or sugar, may limit the success of the extraction healing. I agree to follow the home care instructions provided to me. I agree to report to Dr. Zigler for regular examinations as indicated.

8. To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, any blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

Date Print Name Signature of Patient/Guardian

Date Print Name Signature of Witness