KANIKSU COMMUNITY HEALTH

WHOLE HEALTH FOR YOUR WHOLE LIFE

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Consent Form for Tooth Extractions and Other Oral Surgeries

I hereby give my permission for _____ , DDS to perform the following procedures and such additional procedures as are considered necessary on the basis of findings during said procedure:

Extraction of Tooth/Teeth #'s: _____ _____ _____ _____ _____ _____ _____ _____

And/or _____

I consent this to be done with local anesthesia only and other medications listed below:

A. _____ B. _____

The following alternative methods have been explained to me:

1.
2.
3.

These alternative methods of treatment are practical and possible and after the dentist'sexplanation, I have chosen said procedure(s).
I understand there are various inherent or potential risks that can occur as a result ofsaid procedure(s) despite all efforts to the contrary which include but are not limited to:

- Drug reactions and side effects
- Post-operative bleeding
- Post-operative infection or bone inflammation (dry socket)
- Necessary removal of bone during tooth extraction
- Possible involvement of the sinus of the upper jaw during removal of upper back teeth requiring possible surgery for repair at a future date.
- Possible involvement of the nerve within the lower jaw during removal of lower molar teeth, resulting in usually temporary but possible permanent numbness and/or tingling in the lower lip, right and/or left side.

The dental care and treatment to be performed has been explained to me and I understand what is to be done and that there is no warranty or guarantee as to any result and/or cure from the procedure(s) authorized above.

_____ _____

Date First name Last name Middle initial

_____ _____

Witness Signature of patient or guardian/responsible party