WILLIAM J. CHO, D.D.S., M.S.
Diplomate, American Board of Periodontology
Practice Limited to Periodontics and Dental Implants
3144 El Camino Real, Suite 104, Carlsbad, CA 92008, tel: 760.720.7372, fax: 760.720.7305
e-mail: wjcperio@yahoo.com, website: www.wjcperio.com

Consent for Extraction of Teeth

Extraction of teeth is an irreversible process and whether routine or difficult is a surgical procedure. As in any surgery, there are some risks. They include, but are not limited to:

1. Swelling and or bruising and discomfort in the surgery area.
2. Stretching of the corners of the mouth resulting in cracking and bruising.
3. Possible infection requiring further treatment.
4. Dry socket – jaw pain beginning a few days after surgery, usually requiring additional care, it is more common from lower extractions, especially wisdom teeth.
5. Possible damage to adjacent teeth, especially those with large fillings or caps.
6. Numbness or altered sedation in the teeth, lip, tongue and chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or injured. Sensation most often returns to normal, but in rare cases, the loss may be permanent.
7. Trismus – limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes it is the result of jaw joint discomfort (TMJ), especially when TMJ disease and symptoms already exist.
8. Bleeding – significant bleeding is not common, but persistent oozing can be expected for several hours.
9. Sharp ridges or bone splinters may form later at the edge of the socket. These may require another surgery to smooth or remove them.
10. Incomplete removal of tooth fragments – to avoid injury to vital structures such as nerves or sinuses, sometimes small root tips may be left in place. Sinus involvement: The roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus, or an opening may occur into the mouth which may require additional care.
11. Jaw fracture – while quit rare, it is possible in difficult or deeply impacted teeth.

Most procedures are routine and serious complications are not expected. Those, which do occur, are most often minor and can be treated.

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I have been fully informed of the nature of oral surgery, the procedure to be utilized, the risks and benefits of the surgery, the alternative treatments available, and the necessity for follow-up care and self care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of oral surgery as presented to me during consultation and in the treatment plan presentation as described in this document.

I also consent to use of an alternative treatment or method if clinical conditions are found to be unfavorable for the proposed oral surgery that has been described to me. If clinical conditions prevent the oral surgery, I defer to my periodontist's judgment on the surgical management of that situation, which may include the use of membranes and grafting materials.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____	_____	_____
Date	[Printed Name of Patient, Parent, or Guardian]	[Signature]
_____	_____	_____
Date	[Printed Name of Doctor]	[Signature]
_____	_____	_____
Date	[Printed Name of Witness]	[Signature]

Teeth to be removed: _____