Dental Extraction Informed Consent Form

Patient Information:

- **Name:** ____
- **Date of Birth:** ____________________________________
- **Contact Information:** _______________________________

Diagnosis:

[Provide a brief description of the patient's condition necessitating the extraction.]

Planned Procedure:

[Detail the tooth/teeth to be extracted and a brief overview of the procedure.]

Risks and Complications:

I understand that the following potential risks and complications may occur with dental extractions:

- Bleeding
- Infection
- Dry socket
- Nerve injury
- Sinus involvement
- Fracture of adjacent teeth or restorations
- Jaw fracture
- Delayed healing
- Adverse reactions to medications or anesthesia

Benefits:

[Outline the expected benefits of the extraction, such as relief from pain or prevention of further dental issues.] ____

Alternatives:

[List any alternative treatments, such as root canal therapy, periodontal treatment, or no treatment, including the potential consequences of each.]

Anesthesia Options:

[Specify the type of anesthesia to be used, such as local anesthesia, sedation, or general anesthesia, and discuss associated risks.]

Post-Operative Care:

I acknowledge that I have received and understand the post-operative care instructions, which include:

- Bite on gauze to control bleeding
- Apply ice packs to reduce swelling
- Take prescribed medications as directed
- Avoid smoking and alcohol
- Maintain a soft diet
- Attend follow-up appointments

Patient Acknowledgment:

I have had the opportunity to discuss the proposed treatment with my dentist, including the risks, benefits, and alternatives. I have had all my questions answered to my satisfaction. I understand that no guarantees can be made regarding the outcome of the procedure.

Consent:

By signing below, I consent to the extraction procedure as described above.

Patient Signature: ______________________________ **Date:** ________________

Dentist Signature: ______________________________ **Date:** ________________