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Informed Consent for Extractions/Oral Surgery

I understand it is recommended that I have the following extractions/surgery:

_____

_____*Alternatives have been explained to me, but, are declined.*

_____*I understand that if I choose to do nothing, I may experience pain, infection, and swelling that may compromise adjacent teeth, tissue and facial structures.*

_____*I understand that complications can occur which may require I see another doctor/dentist and I may incur additional expenses.*

_____ *I understand the following risks and complications that may occur:*

Infection Dry Socket Bleeding Bruising Swelling

- *Damage to adjacent teeth, restorations or structures*
- *Sinus Involvement with upper jaw teeth.*
- *Root tip breakage and displacement, bone fragments.*
- *Fracture of jaw or supporting structure.*
- *Nerve damage which may cause a loss of feeling in lips, teeth, tongue, and surrounding areas for an indefinite amount of time, even permanent.*

I understand complications may arise during surgery that require immediate changes to the agreed upon treatment, but, will only be exercised as needed by my clinical judgement and experience.

I agree I have been given the time and attention to answer all of my questions.

_____ _____
Patient Date

_____ _____
Witness Date