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Extraction Consent: Tooth # _____

I understand that the purpose of this surgery is to treat and possibly correct diseased oral tissues. Tooth extraction is usually recommended for a tooth that isn't restorable due to tooth decay and infection, a baby tooth that won't exfoliate on it's own, to create space for permanent teeth to erupt reducing the amount of crowding, and/or when retention of a tooth can adversely affect permanent and adjacent teeth.

The removal of a tooth or teeth is an irreversible process and the doctor has discussed alternative treatments including effects of "non extraction."

There are certain inherent and potential risks with any treatment plan or procedure, and in this instance such risks include but are not limited to:

1. **Swelling, bruising, and pain:** These can occur with any surgery and vary from patient to patient.

2. **Trismus:** This is limited opening of the jaws due to inflammation and/or swelling in the muscles. It is most common with impacted tooth removal but it is possible with any surgery.

3. **Infection:** This is possible with any surgical procedure and may require further surgery and/or medications.

4. **Bleeding:** Although significant bleeding can occur during or after surgery, it is not common. Some bleeding is, however, usual for most surgeries and is normally controlled by following the post-op instruction sheet.

5. **Reaction to local anesthetic:** Certain possible risks exist that, although uncommon or rare, could include pain, swelling, bruising, infection, nerve damage, idiosyncratic or allergic reactions. In very rare and unpredictable cases the reactions to anesthesia medications can be life threatening.
   Also your child may bite his/her lip due to the numbing feeling; this can cause swelling that may last up to 7 day.

6. **Incomplete removal of tooth fragments:** There are times the doctor may decide to leave a small fragment or root of a tooth in order to avoid damage to adjacent structures such as nerves, sinuses, etc., or when removal would further extensive surgery.

7. **Stretching of the corners of the mouth with resultant cracking and bruising:** This may occur due to retraction of the cheeks during surgery.

I, _____ understand that it is my responsibility to notify this office should any unexpected problems occur or if any problems relating to the treatment rendered are experienced.

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the nature and purpose of extraction, and have received answers to my satisfaction. I voluntarily undergo this treatment in hopes of achieving the desired results from the treatment rendered though no guarantees have been made regarding the outcome. I hereby assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment. The fee(s) for these services have been explained to me and I accept them as satisfactory.

By signing this form, I am freely giving my consent to authorize Dr. Mbibi and/or all associates involved in rendering the services or treatment necessary to the existing dental condition, including the administration and/or prescribing of any anesthetic agents and/or medications.

_____ Patient's name (please print)

_____ Signature of parent/legal representative _____Date

_____ Witness to Signature _____Dr's Signature