All Smiles Family Dental
537 E Dundee Rd, Palatine, IL 60074
Ph. 847-907-0585

Informed consent for Tooth Extraction

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Patient's Name (PLEASE PRINT) *Date*

I voluntarily consent to the recommended tooth extraction. I have chosen an extraction, over the alternatives that have been explained to me.

The extraction procedure has been fully explained, including the risks involved. I have been informed that the complications may include, but are not limited to:

- Pain, bruising, and swelling
- Damage to other teeth, fillings, crowns, and bridges
- Nerve or sinus damage, causing temporary or permanent numbness of chin, tongue, lips or face
- Dry socket or healing problems, which may require additional treatment/s
- Blood pooling, which may require drainage
- Fragments of bone or teeth may not be removed at the time of extraction, but may need to be removed in a subsequent procedure
- The jaw may be dislocated or fractured
- Infection at the extraction site or elsewhere requiring additional treatments
- Drug side effects or other drug reactions
- The teeth may shift in the future
- T.M.J problems may occur in the future

I have been informed that the condition of the tooth will worsen and that other systemic problems could develop if the extraction is not done. The consequences of non-treatment may include, but are not limited to:

- Pain, swelling, infection, Periodontal Disease or Systemic Problems

I have had an opportunity to ask questions, and I am fully satisfied with the answers I have received. I have also been given instructions to follow after the extraction and agree to follow the instructions carefully. I understand that I am financially responsible for any dental treatment received regardless of dental insurance.

TOOTH #/s _____

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Patient's or Guardian's Signature Date