SURGICAL EXTRACTION ACCEPTANCE FORM

I understand and it has been explained to me that:

1. I require one or more of my teeth to be extracted.

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

- Swelling, bruising, and/or discoloration of the skin;
- Discomfort in the area of the surgery;
- Stretching of the corners of the mouth which may result in cracking and bruising;
- Infection of the surgical site requiring further treatment;
- Dry socket (jaw pain beginning a few days after surgery, usually requiring additional care)(this is more common from lower extractions, especially wisdom teeth);
- Possible damage to adjacent teeth, especially those with large fillings or crowns. While every attempt is made to protect the adjacent teeth, if damage were to occur then the repair of the adjacent teeth would entail additional fees;
- Numbness or altered sensation in the teeth, lip, tongue, and chin due to the closeness of the 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;
- Trismus (limited jaw opening due to inflammation or swelling, most common after wisdom teeth removal). Sometimes it is the result of jaw joint discomfort (TMJ), especially when TMJ disease and symptoms already exist;
- Bleeding (significant bleeding is not common, but persistent oozing can be expected for several hours);
- Sharp ridges or bone splinters may form later at the edge of the socket. These may require another surgery to smooth or remove;
- 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);
- Jaw fracture (while quite rare, it is possible in difficult or deeply impacted teeth).

3. I understand the above risks and acknowledge that occasionally there are complications with surgery and/or the use of medications. However, I know that some of the above-mentioned complications can be avoided or reduced by following the dentist's instructions.

4. The surgical procedure that is to be performed on me has been explained to me and I understand the nature of my condition and of the proposed treatment. I also understand what health risks exist if the procedure is not done, such as pain, infection, decay, damage to other teeth, and a more difficult procedure as the problem progresses and I grow older.

5. I agree to the administration of local anesthetic and other therapeutic measures (as discussed) that may be necessary for my comfort, safety and well being.

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6. Medications given during or after surgery may cause drowsiness and a lack of coordination, which could be increased with the use of alcohol or drugs. I am aware that I should not operate a motor vehicle or heavy machinery for at least twenty-four (24) hours after taking these medications, or until I have recovered from their effects.

7. I may, at the dentist's discretion, need to be referred to a specialist if the extraction process proves to be particularly complex. All specialist fees will be as between me and the specialist, and Chapel Hill Dental will receive no commission or compensation for work performed by such other specialist.

8. I understand that the dentist may discover additional or different conditions that may require additional or different procedures from those planned. I authorize such procedures as are deemed necessary in my dentist's professional judgment in order to complete my surgery.

9. I acknowledge that I have had time to review this form and ask any questions I may have. I have had all my questions answered to my satisfaction. This is my consent to surgery.

10. **I understand the treatment procedure and wish to proceed.**

Patient (or Legal Guardian) Signature: _____

Print Name: _____

Date: _____