Dental Extraction Consent Form Dr. Casey Coleson, DDS

Patient Name: _____ Date of Birth: _____

Teeth to be Extracted (Tooth Numbers):

_____

(Example: #8, #19, #30, etc. – Universal/ADA numbering system)

1. **Procedure Description:** *I understand* that my dentist recommends removal of one or more teeth. The procedure may include simple or surgical extraction, sectioning of the tooth, removal of bone, and use of local or sedative anesthesia.
2. **Risks and Potential Complications:** *I understand* the risks may include pain, bleeding, infection, dry socket (alveolar osteitis), swelling, bruising, nerve injury, damage to adjacent teeth or crowns, sinus complications, jaw fracture (rare), or need for additional procedures.
3. **Alternatives to Extraction:** Alternatives may include no treatment, root canal therapy, or other restorative options.
4. **Anesthesia Consent:** *I understand* local anesthesia will be used and sedation options explained, along with associated risks.
5. **Post-Operative Expectations:** I may experience discomfort, swelling, bruising, limited mouth opening, and should follow post-op instructions.
6. **Medications and Medical Conditions:** I have disclosed all medical conditions (including but not limited to pregnancy, diabetes, heart conditions, artificial joints or heart valves, osteoporosis treatment (bisphosphonates), bleeding disorders) and all medications, supplements, and allergies (including antibiotics, latex, or local anesthetics).
7. **Benefits of Extraction**: Benefits may include relief from pain or infection, removal of non-restorable teeth, prevention of future complications, improved oral health, and space for orthodontic or prosthetic treatment.
8. **Socket Preservation (Bone Grafting):** Optional Socket preservation may maintain bone, support natural gum appearance, prevent ridge collapse, and improve restorative outcomes. It is optional and may involve additional cost or materials.
9. **Consent and Acknowledgment:** *I understand* the nature, risks, and benefits of the treatment and consent to the procedure.

Patient Signature: _____ Date: _____

Guardian/Representative (if applicable): _____ Date: _____

Doctor Signature: Dr. Casey Coleson, DDS

_____ Date: _____