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PATIENT INFORMATION

Legal Name:____ ❑Male ❑Female
Last First Middle

Preferred Name:______________________________Date (D/M/Y):________________

Tooth Extraction Area(s):________________

SURGICAL EXTRACTION PATIENT INFORMATION AND CONSENT FORM

I have reviewed my medical history with my doctor, including medications, allergies, recreational drugs and other medical conditions. **I AM NOT TAKING MEDICATION RELATED TO OSTEOPOROSIS**._______

To my knowledge , I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions i have had to drugs, food, insect bites, anaesthetics, pollen, dust, blood, or body disease, gum or skin reactions, abnormal bleeding or any other conditions related to my health.________

I have further been informed of the possible risks and complications involved with surgery, drugs, and anaesthesia. I understand that such possible complications include pain, swelling, bruising, discomfort or stiffness in the jaw, bleeding and loss of dental fillings. Less common side effects include,: infection, numbness of the lip, tongue, chin, cheek, or teeth may also occur. Also possible are inflammation of a vein, bone fractures, delayed healing, allergic reactions to drugs or medication used, etc. The exact duration of these complications may not be determinable and may be irreversible._______

I am aware that in some cases a portion of the root may be left in the bone, if removal of that portion would require extensive surgery and bone loss. I understand that this portion of the tooth may remain in place for my lifetime, or may at some point erupt through the gums and may need to be removed._______

I understand that the risk of no treatment, may include: Inflammation, infection, abscess and nerve sensitivity. Also possible are temporomandibular joint (jaw) problems, headaches and referred pain to the back of the neck and facial muscles._______

My Doctor has explained that there is no method to accurately predict the gum and bone healing capability in each patient after the placement of the implant._______

Continued on other side……

I recognize that extensive use of smoking, alcohol, recreational drugs, or sugar may affect healing and may limit the success of the implant. I agree to follow my doctor's home care instructions and agree to report to my doctor for regular examinations as instructed._______

I am aware that the the post-operative complication of DRY SOCKET, may occur, especially if I do not follow the recommendation and post-operative instructions that the dentist has given me, including: NO SMOKING, SPITTING, SUCKING, or PUTTING THINGS IN THE SOCKET. Dry Socket usually appears 3-10 days after the surgery and is very painful and accompanied by a foul taste and odor. This happens because the blood clot has become dislodged from the socket, and the bone is not healing properly, if this happens, I will come to see my dentist as soon as possible for Dry Socket Paste, to aid the pain and the healing process.______

I agree to the type of anaesthesia, depending on the choice of the doctor. I understand that I must not operate a motor vehicle or hazardous device for at least 24 hours or more until I have recovered from the effects of the anaesthesia or drugs administered fro my care.______

I understand that despite the possible complications, my contemplated surgery is necessary and is desired by me._______

I consent to photography, filming, recording, and x-rays of the procedure to be performed for the advancement of surgical dentistry, provided that my identity is not revealed.________

I have had ample opportunity to read this form and ask any questions, and had my questions answered satisfactorily.______

______________________	____________	______________________
Print Name	Date	Signature
______________________	____________	______________________
Doctor	Date	Signature