TREND DENTAL
FAMILY DENTISTRY

INFORMED CONSENT FOR WISDOM TEETH EXTRACTION

This is my consent for the dentist to perform the recommended Wisdom tooth extraction as previously explained to me, or other procedures deemed necessary or advisable to complete the planned procedure.

Teeth to be extracted: _____

Location: _____

I UNDERSTAND that dental treatment requiring **WISDOM TEETH EXTRACTION** and/or **ORAL SURGERY** procedures, which I desire to have performed, include certain risks and possible unsuccessful results or procedural failure. Even though care and diligence will be exercised in this treatment, there are no guarantees of desired or anticipated results, or of the longevity of the treatment. I AGREE to assume the risks, possible unsuccessful results or procedural failure associated with the treatment, including but not limited to the following:

RISKS:

1. **INJURY TO ADJACENT TEETH, FILLINGS, OR CROWNS** may occur no matter how carefully surgical procedures are performed. Fractured fillings or crowns may require replacement.
2. **MUSCLE OR JAW SORENESS** may be noticed following oral surgery and especially wisdom tooth extractions. Anyone with preexisting TMJ issues can see an aggravation of these following wisdom tooth removal. Symptoms of this can include clicking, popping of the TMJ muscle, soreness on opening, and limited range of motion of the jaw following surgery. If these symptoms do not resolve, patients are encouraged to call our office. Patients must **notify us of any such preexisting conditions prior to surgery.**
3. **DRY SOCKET** occurs when the blood clot that forms in the extraction socket of a removed tooth is dislodged, and another clot does not form in its place. These tend to be extremely painful. Drinking liquids through a straw, smoking and simply not following the post-op instructions increase the likelihood of this happening.
4. **INFECTION:** No matter how carefully surgical sterility is maintained, the oral cavity is not a sterile place, and on rare occasion bacteria from your mouth can cause a post op infection. If severe swelling occurs, that is accompanied by a fever and malaise, immediately contact us. Untreated post op infections can result in hospitalization and possibly the use of IV antibiotics.

5. **BLEEDING AND BRUISING** can last for hours after surgery. Should it persist and increase in severity, please contact us immediately. Bruising may be prolonged but tends to be restricted to the cheeks.
6. **SINUS PERFORATION**: in some cases, the root tips of an upper tooth lie close to the sinuses. During extraction, the thin bone that separates the oral cavity from the sinuses can be perforated. Should this occur, closure upon healing is usually seen. In some cases the sinus may need to be repaired.
7. **FRACTURED JAW OR TOOTH ROOTS**: There is a possibility, even though extreme care is exercised, that the jawbone may be fractured requiring a referral to a specialist for treatment. A decision may be made to leave a small piece of root of bone fragment in the jaw as its removal would require extensive surgery or substantially increase the risk of complication during surgery.
8. **INJURY TO THE NERVES OF THE LIPS, TONGUE, THE TISSUES IN THE FLOOR OF THE MOUTH AND CHEEKS, ETC**. These possible nerve injuries can cause numbness, tingling, burning and loss of taste with respect to the tongue. These alterations of sensation usually are temporary, lasting a few days to a few months, however, in rare cases it can be permanent.
9. **UNUSUAL REACTIONS**, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. It is important to take all prescription drugs according to the doctor's instructions.
   If you are a female on oral contraceptives, you must be aware that antibiotics can render those contraceptives ineffective. Caution must be exercised to utilize other methods of contraception during treatment.

_____(Initial) I have **GIVEN AN ACCURATE REPORT OF MY MEDICAL AND HEALTH HISTORY** and certify that I have not omitted or concealed any significant facts regarding my past or present health including any serious problems, injuries, pregnancy, or drug use. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollen, dust etc.

_____(Initial**) I UNDERSTAND THAT DR. HARDEEP ASI IS A LICENSED GENERAL DENTIST WITH RESIDENCY BASED SURGICAL TRAINING** as well as nearly 10 years of experience at removing wisdom teeth. I understand that he is not an oral and maxillofacial surgeon and I choose not to be referred to an oral and maxillofacial surgeon for this procedure.

IT IS MY RESPONSIBILITY TO CONTACT THE DENTIST AND SEEK ATTENTION SHOULD ANY UNDUE CIRCUMSTANCES OCCUR POST OPERATIVELY, AND I SHALL DILIGENTLY FOLLOW ANY PREOPERATIVE AND POST-OPERATIVE INSTRUCTIONS GIVEN TO ME.

INFORMED CONSENT

I have been given the opportunity to ask all questions regarding the nature and purpose of surgical treatment and/or extraction of teeth and have received answers to my satisfaction. I have been given the option of seeking care with an oral and maxillofacial surgeon and voluntarily assume all possible risks, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. By signing this form, I am freely giving my consent to allow and authorize Dr. Asi to render any treatment necessary or advisable to my dental conditions, including all anesthetics and/or medications.

_____RETENTION OF DOCUMENTS RELATING TO YOUR CARE AND AGREEMENT. By signing
(Initial)
this, you understand and agree that it is our policy to scan original documents and store documents in an electronic form. Further, you agree that any agreement bearing scanned signature, which is printed from the electronic form, has the same force and effect as the original document.

Patient's Name (Printed): _____Date: _____

Patient's Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

Witness's Name: _____ Witness's Signature: _____ Date: _____