Extraction Consent Form

I, _____, authorize Dr. R. Mueller to extract the following tooth/teeth_____. I have given a complete and accurate medical history, including all medicines and drug use. I also agree to comply with instructions given to me during my course of treatment. I have been informed of advantages, disadvantages alternatives, and risks concerning my treatment. Extractions are commonly done at Dr. R. Mueller's office, they are considered routine and serious complications are not expected. I understand extraction of teeth is an irreversible procedure and whether routine or difficult it is a surgical procedure. As in any surgery there is some risk. They can include but are not limited to:

- Swelling and or bruising and discomfort in the surgical area.
- Stretching of the corners of the mouth resulting in cracking and bruising.
- Possible secondary infection requiring further treatment.
- Jaw pain beginning a few days after surgery usually caused by a "dry socket" resulting additional care.
- Possible damage to adjacent teeth.
- Numbness or altered sensation in the teeth, lip, tongue. Sensation most often returns to normal, but in rare cases, the loss may be permanent.
- Limited jaw opening due to inflammation or swelling.
- Bleeding during and after the procedure.
- Sharp ridges or bone splinters may form later at the socket, possibly requiring another surgery to smooth or remove them.
- In complete removal of tooth fragments to avoid injury to structures such as nerves or sinuses.
- An opening into the sinus called a perforation can occur when removing upper teeth, which may require additional care.
- Injury to the oral tissues such as lip cheek or tongue.

_____ _____

Patient (or legal guardian) signature Date