LUNAR SMILE DENTISTRY

475 Wharncliffe Rd S, London, ON N6J 2N1
226-884-2573 · info@lunarsmiledentistry.ca
lunarsmiledentistry.ca

PROCEDURE CONSENT

Consent for Extraction of Teeth

Before you sign. Read this form carefully and ask us about anything that is unclear before you sign. Your dentist will go over it with you before treatment begins. To fill it in on a computer, open it in Adobe Acrobat Reader (free), then save it and email it to info@lunarsmiledentistry.ca, or print it and bring it to your appointment.

Patient

Patient full name

Date of birth (YYYY-MM-DD)

Phone

Tooth or teeth to be removed

Reason for removal

- ☐ Infection or abscess
- ☐ Gum (periodontal) disease
- ☐ Tooth cannot be restored
- ☐ Orthodontic reasons
- ☐ Other (describe below)

Other reason / details

If the tooth is not removed

- Infection can continue, grow and spread.
- A spreading infection can become serious, causing fever and illness throughout the body and, very rarely, becoming life-threatening.
- A loose tooth or broken pieces of tooth can be inhaled or swallowed.

Possible complications

These are uncommon, but can happen during or after an extraction:

- pain, swelling and bruising;
- damage to nearby teeth, fillings, crowns or gums;
- nerve injury causing numbness or tingling of the lip, chin or tongue, usually temporary but occasionally permanent;
- dry socket, a painful but non-infected delay in healing of the socket;
- infection;
- reactions to medications, anaesthetic or materials used;
- a small piece of root being left in place when removing it would do more harm than good;
- an opening into the sinus when upper back teeth are removed, which may need further treatment; and
- rarely, a fracture of the jaw that needs further treatment.

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Other options

Removing a tooth is a choice, and it is often not the only one. Depending on the tooth, alternatives can include root canal treatment and a restoration, gum treatment, or no treatment for now. If you go ahead, options for replacing the tooth, such as an implant, bridge or denture, can be discussed.

Aftercare

Follow the spoken and written aftercare instructions you are given, and return for a follow-up visit if we ask you to.

Your consent

Please tick each statement to confirm it is true for you.

- ☐ I have read this form, or had it read to me, and I understand it.
- ☐ My dentist has explained the procedure, why it is recommended, the possible risks, and the other options available to me, including no treatment.
- ☐ I have had the chance to ask questions, and my questions have been answered to my satisfaction.
- ☐ I understand that dentistry is not an exact science and that no particular result has been promised or guaranteed to me.
- ☐ I have given an accurate and complete health history, including medications, allergies, past reactions, and pregnancy if applicable.
- ☐ I will follow the aftercare instructions I am given and return for follow-up if asked.

Consent. I consent to removal of the tooth or teeth listed above. If something unexpected is found during treatment, I allow my dentist to do what is reasonably necessary in my best interest, and I understand this will be discussed with me whenever possible.

Signed by: ○ Patient ○ Parent ○ Legal guardian ○ Spouse / partner ○ Substitute decision-maker

Full name of person signing

Relationship (if not the patient)

Email

Signature

X _____

Date (YYYY-MM-DD)

Sign with the Fill & Sign tool in Adobe Acrobat Reader, or print this page and sign by hand.

For office use

Reviewed with patient by

Witness

Date