Richmond Oral and Maxillofacial Surgery, LLC
1004 Oak Drive
Richmond, IN 47374
(765) 935-1997

CONSENT FOR TREATMENT OF EXTRACTION OF TEETH

Patient Name:_____**Date:**_____

It is required that all patients read and sign consent prior to any treatment. In order for you to give your consent to treatment we feel strongly that you, as the patient, should be given as much information as possible regarding that treatment. We have found that our best patients are our most informed patients. This information is not meant to alarm you, but rather allow you to make an informed decision. We also feel that you should have an opportunity to ask questions and receive satisfactory answers to those questions. We ask that you please take your time and read the following form completely.

Extraction of teeth is an *irreversible* process, and whether routine or difficult, is a surgical procedure. As in any surgery, there are some potential risks and complications. These include, but are not limited to, the following:

1. Swelling, bruising and/or discomfort.
2. Stretching of the corners of the mouth resulting in cracking or bruising.
3. Possible infection requiring additional treatment, including hospitalization.
4. Injury to nerves: In the lower jaw there is a nerve canal for a nerve (inferior alveolar nerve) that supplies feeling to the lower lip, chin, tongue, teeth, gingiva (gums), and cheek. There is also a nerve (lingual nerve) that lies outside the lower jaw that supplies feeling to the tongue. There is a possibility that these nerves could be bumped, bruised, cut, or damaged during the removal of lower teeth, especially 3rd molars (wisdom teeth). If injury were to occur to any one of the previously mentioned nerves, numbness of the lower lip, chin, tongue, teeth, gingiva (gums), and/or cheek could occur. Injury to these nerves can also cause pain (dysesthesia) which can persist indefinitely. Injury to these nerves and the above listed symptoms can also be caused by the local anesthetic injection. *Usually,* injury from the removal of teeth and/or the injection is temporary, but it **could be permanent**. Numbness of the tongue would also result in loss of taste.
5. Dry socket (Alveolar Osteitis) – failure of a normal blood clot to form in the extraction site causing jaw pain, usually requiring additional care.
6. Possible damage to adjacent teeth, especially those with large fillings or crowns, requiring replacement of the filling or crown, extraction, or root canal therapy of the tooth/teeth involved.
7. Injury to the temporomandibular joint (TMJ): Removal of teeth may produce pain, clicking, and/or limitation of motion (Trismus). If you have a preexisting TMJ disorder Dr. Partridge, Hornaday, or Alderman should be notified **before** surgery. Removal of teeth can aggravate a preexisting problem with your TMJ even with the gentlest of care. If a problem with your TMJ should occur further treatment may be necessary.
8. Heavy bleeding. This may require hospitalization and/or a general anesthetic to resolve.

Initials_____

9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.

10. Incomplete removal of tooth fragments: to avoid injury to vital structures such as nerves, vessels, or sinus, tooth roots may be left in place. Rarely, these fragments of tooth may require an additional procedure to remove if they become infected.

11. Sinus involvement: the roots of upper back teeth are often close to the maxillary (upper jaw) sinus and sometimes a piece of the root or entire tooth can be displaced into the sinus which would require additional surgery and/or hospitalization. An opening from the mouth into the maxillary sinus and/or an infection can occur which may require additional surgical procedure(s) and/or hospitalization.

12. Displacement of an upper tooth into a space behind the upper jaw called the infratemporal fossa. This may require hospitalization and a general anesthetic to remove.

13. Jaw fracture - while quite rare, it is possible with removal of impacted teeth or in people with atrophic (small) mandibles (lower jaw). This would require wiring the jaws together and/or hospitalization for an open reduction and internal fixation (application of plates and screws) of the jaw.

14. Nausea and/or vomiting, usually due to medications

15. Accidental swallowing of a tooth, filling, or other foreign material that may require X-Rays at the hospital to determine where the material lodged. Additional procedures and/or general anesthetic may be required to remove the object.

16. I understand when teeth are removed that a space is created. I understand that adjacent teeth either next to or opposing the space may migrate or supererupt into the space which may lead to their removal also if nothing is done to replace the extracted teeth.

17. I understand that no warranties or guarantees of any kind have been made to me or anyone about the results of my surgery or procedure(s). I have been given adequate opportunity to read this entire form and to ask any questions about my surgery or procedure(s) before signing this form. I understand that it is my responsibility to inform my doctor if I wish to try another method of treatment to keep my tooth/teeth rather than undergo surgical intervention. I have been informed of the reason for my surgery, the risks involved, and possible alternate methods of treatment, if any, and I elect to undergo the treatment Dr. Partridge, Hornaday, or Alderman has proposed.

18. I understand and agree that this consent form is valid for all future procedures unless the content changes, at which time I will be given an updated consent form.

19. I certify that I have read and fully understand the terms and words in the above consent and /or any verbal explanations given to me by my doctor and/or his assistants, and that I give my consent voluntarily. I also certify that if I am not the patient that I am the *legal guardian and/or power of attorney* for the patient for whom I am completing this form.

Patient_____ Patient's Signature _____ Date _____

Parent/Legal Guardian/POA Signature _____ Date _____

Witnessed By _____ Date _____