CONSENT FORM FOR TOOTH EXTRACTION

Dr…….. has explained the nature of the treatment, it's purpose, associated risks and alternative treatments to me. I have been given the opportunity to ask questions. I have been given the option of no treatment.

Proposed treatment: Extraction of……..

Possible risks:

- Post-operative pain
- Infection
- Swelling
- Bleeding
- Bruising
- Damage to adjacent teeth or restorations (there will be an additional cost for correction)
- Root fracture resulting in minor oral surgery with stitches
- Failure of extraction requiring referral to hospital or specialist

Tick below what may also apply:

☐ Tuberosity fracture
☐ Oro-antral communication
☐ Temporary or permanent nerve damage

I hereby consent to undergo the dental treatment as described above. I understand the cost of the proposed treatment and associated risks and benefits.

SIGN……. DATE…….

PRINT FULL NAME……..