PARISH DENTAL
Dental & Cosmetic Studio

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7-9 Branch Road, Armley, Leeds, West Yorkshire, LS12 3AQ

Informed Consent Form for Tooth Extraction/Wisdom Tooth Removal

Patient Name: _____

Date: _____

Procedure Description:

This consent form is to confirm that I, _____ [Patient's Name], understand that I am undergoing a tooth extraction procedure, specifically for the removal of a wisdom tooth (or teeth). The procedure involves the removal of the tooth from its socket in the bone.

Potential Benefits:

1. Relief from pain and discomfort.
2. Prevention of further dental complications.
3. Improvement in oral health and, in some cases, orthodontic outcomes.

Risks and Complications:

I acknowledge and understand that the procedure, like all surgical procedures, involves risks and potential complications including, but not limited to:

1. **Pain and Swelling:** Common post-operative effects that can be managed with medication.
2. **Bleeding:** Temporary bleeding post-extraction.
3. **Infection:** Risk of infection at the extraction site.
4. **Dry Socket:** A painful condition where a blood clot fails to form or is lost from the socket.
5. **Damage to Adjacent Teeth:** Rare possibility of damage to nearby teeth or restorations.
6. **Nerve Damage:** Rare risk, which can lead to temporary or permanent numbness or altered sensation.
7. **Sinus Complications:** Particularly when upper wisdom teeth are removed.
8. **Jaw Fracture:** Extremely rare, but possible in complex cases.

Alternatives to Tooth Extraction:

I understand that alternatives to tooth extraction may include:

1. Medication or therapy for infection or pain management.
2. Observation without active treatment, accepting the risks of no intervention.

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Consent:

I confirm that the dentist has explained the procedure, risks, benefits, and alternatives to me, and has answered all my questions. I understand that no guarantees or assurances have been made to me concerning the results of this procedure. I consent to the extraction of my tooth/teeth as explained to me.

I also consent to the administration of local anesthetics and any other medications deemed necessary during the procedure. I understand the importance of following post-operative instructions to aid in my recovery.

Patient Signature: _____

Date: _____

Dentist/Oral Surgeon's Signature: _____

Date: _____