

CONSENT FOR EXTRACTION OF TEETH

You have the right to be informed about your condition and the recommended treatment plan to be used so that you may make an informed decision as to whether or not to undergo the procedure after knowing the risks involved. This disclosure is not meant to alarm you, but is rather an effort to properly inform you so that you may give or withhold your consent.

PATIENT NAME _____ DATE _____

1. There are certain inherent and potential risks and side effects in any surgical procedure, and in this specific instance such risks include, but are not limited to, the following:
 - A. Post-operative discomfort and swelling that may require several days of at-home recuperation.
 - B. Prolonged or heavy bleeding that may require additional treatment.
 - C. Injury or damage to adjacent teeth or fillings.
 - D. Post-operative infection that may require additional treatment.
 - E. Stretching of the corners of the mouth that may cause cracking and bruising, and may heal slowly.
 - F. Restricted mouth opening for several days, sometimes related to swelling and muscle soreness; and sometimes related to stress on the joints of the jaw (TMJ).
 - G. The decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
 - H. Fracture of the jaw (in more complicated extractions).
 - I. Injury to the nerve underlying lower teeth, resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue which may persist for several weeks, months or, in rare instances, permanently.
 - J. Opening of the sinus (a cavity situated above the upper teeth) requiring additional surgery.
2. During the course of the procedure(s) unforeseen conditions may be revealed which will necessitate extension of the original procedure(s) or different procedures from those set forth. I authorize Dr. Gustave and his staff to perform such procedures as are necessary and desirable in the exercise of professional judgment.
3. Certain medications, drugs and anesthetics which I may be given can cause drowsiness, incoordination and lack of awareness which also may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or machinery and not to work while taking such medication or until fully recovered from the effects of same. I understand the recovery may take up to 24 hours or more after the last dose is taken. If I am given an oral sedative, I agree not to drive myself home and will have a responsible adult drive me home and stay with me until I am fully recovered from the effects of the sedation.
4. I understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed.

My signature here (or that of my Legal Guardian) indicates that I (or my Legal Guardian) have read the information listed above.

Signature of Patient (or Legal Guardian)

Date

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Do NOT sign this portion of the form until you and/or your Legal Guardian have discussed it with Dr. Gustave.

- 5. I hereby authorize Dr. Gustave and any other assistants or employees selected by him to treat the condition(s) described as: _____

- 6. I consent to the administration of _____ anesthesia in connection with the procedure(s) referred to above.

- 7. The procedure(s) necessary to treat the condition(s) has been explained to me and I (or my Legal Guardian) understand the nature of the procedure(s) to be: _____

- 8. I (or my Legal Guardian) have been informed of possible alternative methods of treatment (if any) including: _____

- 9. It has been explained to me, (or my Legal Guardian) and I (or my Legal Guardian) fully understand, that a perfect result is not and cannot be guaranteed or warranted.

My signature (or that of my Legal Guardian) certifies that I (or my Legal Guardian) speak, read and write English and have read and discussed with Dr. Gustave and his staff, and fully understand this consent for surgery form and that all blanks were filled in prior to it being signed.

Signature of Patient (or Legal Guardian) Date

Frederick Gustave, DDS Date

Signature of Witness Date