ABSOLUTE DENTAL CARE
Family, Reconstructive & Implant Dentistry

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Patient: _____ Date of Consent: _____ Extraction Date: _____
B/P: _____
Pulse: _____

EXTRACTIONS & WISDOM TEETH REMOVAL
WRITTEN INFORMED CONSENT

The dentist has explained that I have the following condition: *(Dentist to document in patient's own words)* _____.

The following dental treatment will be performed: Removal or extraction of teeth, teeth numbers _____.
(Oral surgeon / dentist to document number of teeth to be removed).

There will be some pain and swelling following a tooth extraction. This may require pain killers. There will also be bleeding of the socket. This is usually minor and easily controlled by applying pressure.

See "About your anesthetic" information sheet for information about the anesthetic and the risks involved. If you have any concerns, talk these over with your anesthetist. If you have not been given an information sheet, please ask for one.

RISKS:
There are some risks / complications, which include:

(a) Infection of the extraction socket (dry socket). This may cause some pain and discomfort, but is usually easily managed by the oral surgeon/ dentist.

(b) Biting of the numb lip which may cause damage after the teeth have been removed. Children should be watched closely by your parent/ guardian until the numbness wears off.

(c) Damage to the Inferior Dental Nerve on each side of the Mandible (lower jaw). This nerve passes very close to the root of the lower wisdom tooth (often in contact with it) and gives feeling to the lower teeth, lower lip and chin on that side. This nerve is very close to the area of surgery, with a slight risk of some damage to the nerve. This may cause numbness of the lower teeth, lower lip and chin. This may be temporary (6–12 months) or permanent.

(d) Damage to the Lingual Nerve on each side of the Mandible (lower jaw). This nerve passes very close to the tongue side of the lower wisdom tooth and posterior mandibular teeth and gives feeling and taste to that side of the tongue. This nerve is very close to the area of surgery, with a slight risk of some damage to the nerve. This may cause numbness and loss of taste to that side of the tongue. This may be temporary (6–12 months) or permanent.

(e) The tooth root tip may break off in small pieces – less than 1mm - when the tooth is taken out. The oral surgeon/ dentist may not remove those pieces if there is a chance that the nerves or other structures may be damaged during removal.

(f) Damage to teeth growing tightly against the wisdom teeth during removal of the wisdom teeth.

(g) Weakness of the jaw due to removal of the wisdom teeth. The jaw may break during the procedure or during the healing period.

(h) If the upper teeth are close to the sinuses, removal may cause a hole between the mouth and the sinus. This may need further surgery.

Patient: _____ Date of Consent: _____ Extraction Date: _____

B/P: _____

Pulse: _____

PATIENT CONSENT: **By my signature below, I expressly acknowledge that:**

The dentist has explained my dental condition and the proposed procedure, which I understand to be _____ (Patient Initials:_) The dentist has explained any significant risks and problems specific to me, and the likely outcomes if complications occur. The dentist has also explained relevant treatment options as well as the risks of not having the procedure.

I understand the risks of the procedure, including the risks that are specific to me, and the likely outcomes. The dentist has explained other relevant treatment options and their associated risks. The dentist has explained my prognosis and the risks of not having the procedure.

I was able to ask questions and raise concerns with the dentist about my condition, the procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction. I understand that other dental procedures may be done if further dental disease is found during the procedure, or to correct other problems in my mouth. I understand that the dental treatment may include a blood transfusion. I understand that if teeth are removed during the dental treatment, that these may be retained for training purposes and then disposed of sensitively. I understand that a dentist other than the examining dentist may do the procedure. The dentist has explained to me that if immediate life-threatening events happen during the procedure, they will be treated accordingly. I understand that photographs or video footage may be taken during my operation. These may then be used for teaching health professionals. I will not be identified in any photo or video. I understand that no guarantee has been made that the procedure will improve the condition, and may make my condition worse.

On the basis of the above statements, **I REQUEST TO HAVE THE PROCEDURE LISTED HEREIN.**

Name of Patient **:** _____

Signature **:** _____

Date **:** _____

I have been given a translation in _____ (*state the patient's language here*) of the consent form and any verbal and written information given to the patient/ parent or guardian/ substitute decision maker by the dentist.

Name of Interpreter **:** _____

Signature **:** _____

Date **:** _____

I have explained: the patient's condition, need for treatment, the procedure and the risks, relevant treatment options and their risks, likely consequences if those risks occur, the significant risks and problems specific to this patient. I have given the patient/ substitute decision-maker an opportunity to ask questions about any of the above matters, raise any other concerns which I have answered as fully as possible. I am of the opinion that the patient/ substitute decision-maker understood the above information.

Name of Dentist **:** _____

Signature **:** _____

Date **:** _____