Chester Family DENTISTRY

Ana M. Chester, D.D.S, Inc.
140 Highland Terrace Blvd.
Warren, OH 44484

P: 330-505-9668
F: 330-505-9662
E: chesterfamilydental@gmail.com

ORAL SURGERY AND/OR CONSENT FOR EXTRACTION(S)

Current standard of care in dentistry requires that I obtain your informed consent prior to performing an extraction(s). What you are being asked to sign is a confirmation that I have discussed your contemplated procedure, and I have informed you of all risks, benefits, and ramifications of this procedure and additionally, alternative treatments with their risks and benefits.

I authorize Dr. _____ (herein referred to as "the dentist") to treat the following conditions:

Procedure being performed: _____

_____

_____

- I also authorize the dentist to perform any additional procedure(s) such as: alveoplasty (smoothing of the bone) or bone grafting if deemed necessary in his/her judgement to accomplish optimal results.
- I understand that there are possible side effects or allergic reactions to any medications including nausea, vomiting, constipation, dizziness, itching, hives, swelling of the tongue, lips, or face, breathing difficulty or cardiac arrest (death).
- I understand that there are possible risks of the procedure:
    - Pain, discomfort, bruising, bleeding, swelling, sore throat or difficulty swallowing – (any or all possibly severe at times) necessitating several days of home recuperation.
    - Stretching or abrasion of the lips or corners of the mouth resulting in soreness, pain, difficulty opening and eating – (lasting several days or weeks).
    - Swallowing or aspiration (breathing in) of part of the tooth, filling or debris.
    - Injury to adjacent teeth and gums or loss or loosening of fillings and crowns (caps).
    - Sensitivity to adjacent teeth to cold food and liquids for weeks or months.
    - Trismus (restricted mouth opening) lasting several days or weeks.
    - Postoperative infection that may require additional treatment, possibly hospitalization.
    - Bone spicules (particles), root fragments, sharp edges of bone or food debris causing irritation, pain, swelling or infection presenting days or weeks after surgery.
    - Dry socket (loss of blood clot from extraction site) or painful socket that may require additional care.
    - Numbness (loss of feeling) of the lip(s), chin, cheek(s), face, gums, and/or tongue with loss of taste, that usually resolves in weeks or months but could remain permanently.
    - For upper teeth – opening into the sinus or nasal cavity or sinus complications or infection possibly requiring a second procedure with additional costs.
    - Decision to leave small root tips in the jaw when its removal could require extensive surgery or risk other complication such as damage to the nerve or sinus.
    - If intravenous access used – soreness, swelling, bruising, infection or phlebitis (inflammation at the injection site or along the course of the vein).

- Temporomandibular joint (jaw joint) dysfunction and pain.
- Weakening or fracture of the jaw or part of the jaw (alveolar process, tuberosity) surrounding the tooth.
- Allergic reactions (previously unknown) to any medications used in treatment.
- Other: _____

  _____ .

I certify that the medical history I have given is accurate and complete to the best of my knowledge. I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s). I realize in spite of the possible complications, my contemplated treatment is necessary and that I understand all the risks, benefits, and ramifications of this procedure and all of the alternative treatments, including the option of doing no treatment at all. I agree to follow all of the dentist's instructions and recommendations (**INCLUDING TAKING ALL PRESCRIBED MEDICATIONS UNTIL THEY ARE FINISHED**). I agree to contact Chester Family Dentistry at any time, day, night or weekend for any problem during and after my postoperative period. I certify that I have read and fully understand this consent for surgery and all questions about the procedure have been answered to my satisfaction.

_____ _____

PATIENT NAME DATE