Crown Dental Studio

INFORMED CONSENT FOR EXTRACTIONS AND SOCKET PRESERVATION

The treating dentist has fully explained to me the purpose of the operation/procedure and has also informed me of all expected benefits and complications (from known and unknown causes) associated with the recommended treatment. The discomforts and risks that may arise have been thoroughly explained. The risks discussed include, but are not limited to the following:

1. Injury of adjacent teeth and/or fillings.
2. Loose teeth.
3. Removal of alveolar bone along with an extracted tooth.
4. Fractured roots and the possibility of leaving a portion of the root in the jaw.
5. Nerve damage after mandibular surgery resulting in temporary or permanent numbness of the lower lip, chin, or tongue.
6. Damage to anatomical structures (i.e. blood vessels, nerves, glands, etc.).
7. Fusion of teeth resulting in the removal of two/multiple teeth.
8. Extraction of adjacent teeth with diminished bone support.
9. Dislodged tooth into the maxillary sinus or soft tissue.
10. An opening into the sinus or sinus infection.
11. Fractured jaw.
12. Injury to a tooth bud (forming permanent tooth).
13. Bleeding.
14. Infection.
15. Dry Socket.
16. An unresolved infection.
17. Temporomandibular joint trauma.
18. Severe pain or inflammatory swelling (edema).
19. Postoperative stiffness or limited jaw opening.
20. Small, loose bony spicules (sequestrum) or bony irregularities.
21. Failure of bone graft – requiring further treatment and need for graft to be re-done.

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I understand that during the course of the procedure unforeseen conditions may arise which necessitate procedures different from those contemplated. I therefore consent to the performance of additional procedures which CROWN DENTAL STUDIO may consider necessary.

The possible treatment alternatives (including no treatment) have been reviewed. If I don't have the procedure completed, my condition may stay the same, improve, or get worse. It is the doctor's opinion that the proposed procedure is a better option for me. The treating dentist has also explained the consequences of not having the extraction completed.

The practice of dentistry and surgery is not an exact science. Although good results are expected, the doctor has not given me any guarantee that the proposed treatment will be successful, will be to my complete satisfaction, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, need for more treatment, or worsening of my present condition despite careful treatment.

The benefits, risks, and complications associated with local anaesthesia and sedation have been thoroughly reviewed with me. The risks discussed include, but are not limited to: partial or complete paralysis of facial nerve(s), hematoma (a swelling that contains blood), fracturing of the anaesthetic needle, temporary or permanent numbness, allergic reaction, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac conditions, decreased heart rate, and depressed breathing. If applicable, I will arrange for someone to drive me home after I have received oral sedation, and to have someone watch me closely after my dental appointment to observe for side effects such as difficulty breathing or passing out.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. I confirm that I have read and fully understand the above and I agree to cooperate completely with the doctor's recommendations.

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I UNDERSTAND THAT TREATMENT OF DENTAL CONDITIONS INCLUDES CERTAIN RISKS AND POSSIBLE UNSUCCESSFUL RESULTS, INCLUDING THE POSSIBILITY OF FAILURE. NO PROMISES OR GUARANTEES HAVE BEEN MADE TO ME CONCERNING THE PROGRESSION OR RESULTS OF THE TREATMENT. BY SIGNING THIS FORM, I AM FREELY GIVING MY CONSENT TO ALLOW AND AUTHORIZE CROWN DENTAL AND/OR THEIR ASSOCIATES TO RENDER ANY TREATMENT NECESSARY OR ADVISABLE TO MY DENTAL CONDITIONS, INCLUDING ANY AND ALL ANAESTHETICS AND/OR MEDICATIONS. I CONFIRM THAT CROWN DENTAL STUDIO OR ANY OF ITS AFFILIATES SHALL NOT BE HELD LIABLE FOR ANY UNSUCCESSFUL RESULTS. I HAVE GIVEN A COMPLETE AND TRUTHFUL MEDICAL HISTORY, INCLUDING ALL MEDICINES, DRUG USE AND PREGNANCY.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

I HEREBY CONSENT AND AGREE TO RECEIVE THE FOLLOWING ALTERNATE TREATMENTS IN THE EVENT OF THE DESIRED RESULTS NOT BEING ACHIEVED:

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____
4. _____
   _____
   _____
5. _____
   _____
   _____

Crown Dental Studio

PATIENT PARTICULARS:

FULL LEGAL NAME: _____

IDENTITY NUMBER: _____

ADDRESS: _____

_____

_____

CONTACT NUMBER: _____

EMAIL ADDRESS: _____

Accepted and Signed at _____ on this _____ day of _____ 20_____

in the presence of the undersigned witnesses

_____

PATIENT NAME:
IDENTITY NUMBER:
CONTACT NUMBER:
EMAIL ADDRESS:

Witnesses:

1. _____
   NAME:
   CONTACT NUMBER:
2. _____
   NAME:
   CONTACT NUMBER:

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