REYNOLDS
ORAL & FACIAL
SURGERY

CONSENT FOR EXTRACTIONS

Patient's Name:_____ **Date**_____

PLEASE CHECK EACH BOX AFTER READING. **If you have any questions please ask your doctor.**

- ❑ I authorize Dr. Reynolds/Dr. Auble to perform the following procedure(s):Removal of tooth #(s) _____
- ❑ These procedures are necessary to treat the following condition(s):_____
- ❑ The possible alternate methods of treatment (if any), include:_____
- ❑ I understand that I will be receiving local anesthesia to numb the area of surgery.
- ❑ I may also choose (❑Nitrous Oxide ❑ IV Sedation ❑General Anesthesia; these require that you sign an additional consent)❑ NONE of these
- ❑ I understand that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include but are not limited to:
  - ❑ Damage to adjacent teeth or fillings that may require future root canal procedures, or may cause loss of those teeth.
  - ❑ Post operative pain and swelling that may necessitate several days of at-home recuperation.
  - ❑ Heavy bleeding that may be prolonged.
  - ❑ Post-operative infection that may require additional treatment.
  - ❑ Injury to the lips from surgical instruments.
  - ❑ Stretching of the corners of the mouth with resultant cracking and bruising.
  - ❑ Restricted mouth opening for several days or weeks, from stress on the jaw joints (TMJ). Existing TMJ problems may be worsened.
  - ❑ Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
  - ❑ Fracture of the jaw.
  - ❑ Injury to the nerve resulting in numbness or pain in the lower lip, chin, tongue (including loss of taste sensation), cheek, gum, lower front teeth and area of the donor or recipient site, or more extensive areas, which may be temporary or permanent.
  - ❑ Penetration of the sinus or nasal cavity in the upper jaw, which could result in infection or other complication requiring additional drug or surgical treatment.
  - ❑ Dry socket.
  - ❑ Allergic reaction (previously unknown) to any of the medications used.
  - ❑ Swallowing or aspirating (inhaling) a tooth or other object during the procedure.
  - ❑ Exposure of bony fragments or prominences coming through the gums after surgery during the healing phase which may require further surgery.
  - ❑ Other:_____

ADDITIONAL AGREEMENTS AND AUTHORIZATIONS

_____ *(Initial)* I understand smoking is extremely detrimental to the success of this surgery. **I state that I have ceased all use of tobacco for at least 48 hours prior to and after surgery.**

- ❑ Recognizing that during the surgery some unforeseen condition may be discovered that may necessitate a change in approach or different procedure from those explained above, I authorize Dr. Reynolds/Dr. Auble to perform such procedures as are necessary and advisable in the exercise of his professional judgment.
- ❑ No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that the treatment would be helpful, and I have weighed the risk with the proposed benefits.
- ❑ I have discussed my past medical history with the doctor and have disclosed **ALL** diseases and medications, including alcohol and drug use past and present.
- ❑ I agree to cooperate completely with the recommendations of Dr. Reynolds/Dr. Auble, realizing that lack of cooperation may result in a less than optimal result.
- ❑ I have reviewed / viewed pre-operative and post-operative instructions.
- ❑ I understand that oral hygiene will be difficult following surgery, but will do my utmost to follow normal tooth brushing and oral hygiene routines.

I certify that I have had an opportunity to read and fully understand the terms within the above consent and the explanation made, and that all blanks or statements requiring completion were filled in, and any inapplicable paragraphs were stricken before I signed. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the procedure.

Patient's (or Legal Guardian's) Signature	Date
Doctor's Signature	Date
Witness' Signature	Date