Tooth Extraction Informed Consent Patient's Name Date of Birth

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. You have been informed of your diagnosis, the planned procedure, the risks and benefits, alternatives associated with the procedure, and any associated costs. Before deciding whether to proceed with the planned procedure, you should consider all of the above, including the option of declining treatment. Your doctor will be happy to answer any questions you may have and provide additional information before you decide to sign this document and proceed with the procedure.

| Procedure Being Performed: | |
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- 1. I have been informed of and 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:
 - Pain, swelling, bruising, prolonged bleeding, delayed healing, injury to adjacent teeth and fillings that
 may result in tooth repair or loss, loose tooth/teeth or damage to dental appliances, stretching of the
 corners of the mouth with resultant cracking and bruising and/or cuts inside the mouth or on the lips,
 fracture of the jaw, stress or damage to the jaw joints (TMJ), limited mouth opening or difficulty
 chewing for several days or weeks;
 - Post-operative infection requiring additional treatment;
 - Decision to leave a small piece of root in the jaw when its removal would require extensive surgery;
 - Nerve injury which may occur from the surgical procedure and/or delivery of local anesthesia, resulting in numbness, tingling or altered sensation of the chin, lip, cheek, gums, and tongue (including loss of taste) on the operated side. This may persist for several weeks, months, or in rare instances, be permanent;
 - Opening in the sinus (a normal cavity situated above the upper teeth) requiring additional treatment;
 - Dry socket (slow healing) resulting in jaw pain that increases a few days after surgery;
 - Sharp ridges or bone splinters may form where the tooth was removed possibly requiring additional surgery.
- 2. I have elected to proceed with the anesthesia(s) indicated below:
 - ☐ Local Anesthesia (no sedation just numbing the area)
 - □ Nitrous Oxide (Laughing gas)
 - □ IV Sedation (Recommended for wisdom teeth removal)

I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:

- Allergic or adverse reactions to medications or materials;
- Pain, swelling, redness, irritation, numbness and/or bruising in the area where the IV needle is placed. Usually the numbness or pain will resolve, but in some cases it may be permanent;
- Nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness. Some patients may have awareness of some or all of the events of the surgical procedure after it is over;
- Heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest) or death:
- Sore throat or hoarseness if a breathing tube is used;
- Due to the potential for nausea and vomiting under anesthesia, I understand that I am not to eat or drink <u>anything</u> (or have not had anything) by mouth for at least 6 to 8 hours before my surgery. TO DO OTHERWISE MAY BE LIFE THREATENING!

If I have elected for IV sedation, I have been instructed to take my regular medications and/or any other medication

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| given to me by my doctor before surgery using only small sips of given during surgery and prescriptions I may be given can cause of worsened by the use of alcohol and other drugs. I have been adversal machinery and not to work while taking such medication or until understand this recovery may take up to 24 hours or more after the sedative medication during my surgery, I agree not to drive myse adult to drive me home and accompany me until I am fully recovery | drowsiness and/or lack of awareness which may be ised not to operate any vehicle or hazardous fully recovered from the effects of the same. I the last dose of medications. If I am to be given If home, and I will have or do have a responsible | | |
| Protein-Rich Fibrin (PRF) is a natural byproduct derived from you sample of blood and processing it in a centrifuge to concentrate used to promote healing, reduce inflammation, and support tissurprocedures. To obtain the PRF, an additional needle poke will be blood draw, you may experience temporary bruising or slight swe short-term and resolve on their own. By signing below, you acknow have been explained to you, and you consent to the blood draw a | platelets and growth factors. PRF is commonly ue regeneration following dental or surgical required to collect your blood sample. As with any elling at the draw site. These effects are typically byledge that the purpose and procedure of PRF | | |
| If I am a female using oral contraceptives, I understand that I will need to use additional forms of birth control one complete cycle of birth control pills, as antibiotics and other medications may interfere with the effective of oral contraceptives. I have been informed of and understand that follow-up visits or care, additional evaluate treatment or surgery, and/or hospitalization may be needed. If any unforeseen condition should arise in the of the operation and while under anesthesia, I further authorize the doctor to modify the procedure if, in his professional judgement, it is in my best interest. | | | |
| In order to increase the chance of receiving optimal results, I have history, including all past and present dental and medical condition medications, any allergies, recreational drug use, and pregnancy discuss this with Dr. Burns. I agree to cooperate completely with under his care, realizing that any lack of the same could result in Burns is not an oral and maxillofacial surgeon and is also not an area. | ons, prescription and non-prescription (if applicable) and have had the opportunity to the recommendations of Dr. Burns while I am a less than optimal result. I understand that Dr. | | |
| It is my responsibility to seek attention should any circumstance follow any preoperative and postoperative instructions given to | | | |
| INFORMED CONSENT : I have been given the opportunity to ask surgical treatment and have received answers to my satisfaction. including the risk of substantial harm, if any, which may be associobtaining the desired results, which may or may not be achieved me concerning results of the treatment or my recovery. By signin and authorize any treatment necessary or advisable to my own or anesthetic and/or medications. | I voluntarily assume any and all possible risks, iated with any phase of this treatment in hopes of . No guarantees or promises have been made to g this form, I am freely giving my consent to allow | | |
| PLEASE ASK DR. BURNS IF YOU HAVE ANY QUESTIONS CONCERN | NING THIS CONSENT FORM. | | |
| Patient's (or legal guardian's) signature | Date | | |

Date

Date

Witness' signature

Doctor's signature