Patient Name________________________

PERIO, PLLC
Dr. John M. Remien DDS, MS

CONSENT FOR TOOTH EXTRACTION

Our practice is committed to providing our patients with the finest care possible. This includes informing you of the positive and negative possibilities of treatment as well as alternatives. We are guided by our obligation to you and the ethical standards of our profession which require written informed consent signed by the patient.

Specific Points Related to Surgical Treatment

(1) Diagnosis: After a careful oral examination and study of my dental condition, my periodontist has advised me that there is/are a tooth/teeth that cannot be saved due to periodontal disease, root canal failure, root fracture or non-restorability.

(2) Recommended Treatment: In order to treat this condition, my periodontist has recommended the extraction of tooth/teeth#_______________________________.

During this procedure, my gum may need to be opened to permit better access to the tooth being extracted. My gum will then be sutured back into position and a periodontal bandage or dressing may be placed. A barrier may be placed, with or without a bone graft, at the time of extraction.

(3) Expected Benefits: The purpose of the extraction(s) is to eliminate infection and/or decrease bone destruction caused by advancing periodontal disease, or to encourage bone regeneration for subsequent placement of dental implant(s).

(4) Principal Risks and Complications: I understand that complications may result from the tooth extraction, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling and pain, facial discoloration, transient but on occasion permanent numbness of the jaw, lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasm, transient but on occasion permanent increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, shrinkage of the gum upon healing resulting in elongation of some of the teeth and greater spaces between some teeth, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, and accidental swallowing of foreign matter. The exact duration of any complications cannot be determined, and they may be irreversible.

There is no method that will accurately predict or evaluate how my gum and bone will heal. In addition, the complications associated with tooth extraction can be affected by medical conditions, dietary and nutritional problems, smoking, alcohol consumption, clenching and grinding teeth, inadequate oral hygiene, and medications that I may be taking. To my knowledge, I have reported to my periodontist any prior drug reactions, allergies, diseases, symptoms, habits, or conditions, which might in any way relate to this surgical procedure. I understand that my diligence in providing the personal daily care recommended by my periodontist and taking all prescribed medications are important to the ultimate success of the procedure.

(5) Alternative To Suggested Treatment: I understand that alternatives to the extraction of hopeless teeth include: (a) no treatment- with the expectation of possible advancement of my condition, (b) non-surgical scraping of tooth roots and lining of the gum (scaling and root planing), with the expectation that inflammation will continue and possible additional bone loss will occur and, (c) bone regenerative surgical procedures including osseous grafting and or guided tissue regeneration

which may or may not improve the prognosis of the tooth/teeth. I also understand that the inflammation around the affected tooth may cause bone loss around the adjacent teeth, which will compromise their long-term prognosis.

I recognize that natural teeth and appliances should be maintained daily in a clean, hygienic manner. I will need to come for appointments following my extraction/surgery so that my healing may be monitored and so that my periodontist can evaluate and report on the outcome of extraction/surgery upon completion of healing. Smoking or alcohol intake may adversely affect gum healing and may limit the successful outcome of my surgery. I know that it is important (1) to abide by the specific prescriptions and instructions given by the periodontist and (2) to see my periodontist and dentist for periodic examination and preventative treatment. Maintenance also may include adjustment of prosthetic appliances.

(6) No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. In most cases, the treatment should provide benefit in reducing the cause of my condition and should produce healing which will help me keep my teeth. Due to individual patient differences, however, a periodontist cannot predict certainty of success. There is a risk of failure, relapse, additional treatment, or even worsening of my present condition, including the possible loss of certain teeth, despite the best of care.

(7) Publication of Records: I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry. My identity will not be revealed to the general public, however, without my permission.

Patient's Statement of Consent

I have been fully informed of the nature of tooth extraction, the procedure to be utilized, the risks and benefits of such surgery, the alternative treatments available, and the necessity for follow-up and self care. I have had an opportunity to ask any questions I may have in connection with the treatment and to discuss my concerns with my periodontist. After thorough deliberation, I hereby consent to the performance of tooth extraction as presented to me during consultation and in the treatment plan presentation as described in this document. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of my periodontist.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT

Patient's Signature (or Parent/Guardian) ___________________________Date __________