

**Menlo Park Dental Excellence
ChauLong Nguyen, D.D.S., F.A.G.D.
724 Oak Grove Avenue, Suite 120
Menlo Park, CA 94025
(650) 838-0260**

INFORMED CONSENT FOR TOOTH EXTRACTION

I _____, hereby authorize **Dr. ChauLong Nguyen** to extract the following tooth (teeth): _____. I have been informed of the need to have the tooth (teeth) removed. The details of the procedure have been explained to me, and I fully understand them. I have been told about the alternatives to the extraction(s), the risks and the benefits. I understand that following the extraction(s) there may be a period of numbness of the jaw, some swelling, bleeding, discoloration, and possible discomfort.

I understand that because the position of the nerves in the area of the extraction(s) cannot be determined by x-rays, injury to the nerves may be unavoidable and may result in loss of sensation to the chin, lips, and tongue for a period of time. I have been told that although it is usual for the numbness to be temporary, it may on rare occasions be permanent.

I understand that the following additional complications, although rare, may occur: sinus cavities when the tooth/roots are in the upper jaw. Surgery in the upper back areas of the mouth runs the risk of sinus perforations, reaction to medications/anesthetic, damage to nearby teeth and restorations, post treatment bleeding, post treatment infection, post treatment tissue swelling and bruising, post treatment sensitivity and pain.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the extraction(s), I agree to report them to the office as soon as possible.

I have been told that the success of the extraction(s) depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication, and reporting to the office any change in my health status.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained. I certify that I have read and fully understand the above consent to the extraction(s).

I have discussed all of the above with the doctor and have had all of my questions answered.

Patient Signature

If a Minor, Signature of Parent/Guardian

Witness (Staff Member)

Date

As part of this consent agreement, I give my personal pledge as a healthcare professional dedicated to the well-being of my patient to make every reasonable effort to assure this patient receives the best possible care with the least possible risk.

Doctor