Menlo Park Dental Excellence-ChauLong T Nguyen Dental Corporation
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Discussion and Informed Consent for Extractions

Patient Name: _____ **Date**:_____

Diagnosis
Dr. Nguyen's initial required:
_____Severe large cavity to bone and furcation of tooth #_____
_____Root fracture causing abscess/infection and bone loss of tooth #_____
_____Localized/ Generalized Severe periodontitis of tooth#/ teeth #s_____
_____Failed root canal therapy tooth#_____
_____Crowded teeth required extraction for orthodontic treatment in tooth# / teeth #s_____

Treatment:
1. Extraction of tooth #/ Teeth #s _____
2. Bone Graft in tooth # , Teeth #s _____
3. Immediate implant placement tooth / Teeth #s_____
4. Use autogenous connective tissue graft on surfaces of tooth #/ Teeth #s_____
5. Doing nothing after extraction and other alternatives discussed on page 3.

Prognosis:
_____Favorable
_____Poor
_____Hopeless

Facts for Consideration - Patient's initials required

_____An extraction involves removing one or more teeth. Depending on their condition, extraction may require sectioning the teeth or trimming the gum or bone tissue. If any unexpected difficulties occur during treatment, Dr. Nguyen may refer you to an oral surgeon, who is a specialist in dental surgery. I can stop now to see a specialist before proceeding further.

_____Once the tooth is extracted, you will have a space that you may want to fill with fixed or removable appliances. Replacement of missing teeth may be necessary to prevent the drifting of adjacent and/or opposing teeth to maintain function, or for cosmetic appearances. The options of a fixed or a removable appliance will be explained to you.

_____As in all surgical procedures, extractions are not without potential risks or complications. Since each person is unique and responds differently to surgery, the healing process may vary; no guarantees can be made.

_____ Extracted teeth that are not replaced may lead to other teeth moving or drifting, creating spaces between the remaining teeth and making it difficult or impossible to replace or straighten them later. If left for a significant period of time, this drifting of teeth may lead to a "malocclusion" (bite) in which top and bottom teeth do not "fit" together as they once did.

Benefits of Extraction, Not Limited to the Following:

_____The proposed treatment is intended to help relieve your symptoms and may also enable you to proceed with further proposed treatment.

Risks of Extraction, Not Limited to the Following:

_____I understand that following treatment I may experience bleeding, pain, swelling, and discomfort for several days, which may be treated with pain medication. It is possible infection can follow extraction and must be treated with antibiotics or other procedures. I will contact the office immediately if symptoms persist or worsen.

_____I understand that I will receive a local anesthetic and/or other medication. In rare instances patients have a reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury can result from an injection resulting in numbness of the lip, chin, sheet, gums, teeth, or tongue, including loss of taste.

_____I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. **Therefore, it is critical that I tell my dentist of all medications I am currently taking, which are**:

_____

_____

_____I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a most significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

_____I understand that the necessary blood clot that forms in the socket may disintegrate or dislodge. This painful condition, called dry socket, lasts a week or more and is treated by placing a medicated dressing in the tooth socket to aid healing. To protect against developing dry socket I must not smoke, drink through a straw, rinse with water or mouthwash, chew food in that area, or disturb the socket in any way for 24 to 48 hours. Smoking may adversely affect the extraction site healing and may cause “dry socket” (an infection of the bone of the socket walls). Smokers are at higher risk for “dry socket” and have more dry sockets than non-smokers.

_____I understand that the instruments used in extracting a tooth may unavoidably chip or damage adjacent teeth, which could require further treatment to restore their appearance or function.

_____I understand that upper teeth have roots that may extend close to the sinuses. Removing these teeth may temporarily leave a small opening into the sinuses. Antibiotics and additional treatment may be needed to prevent a sinus infection and help this opening to close. If such a complication occurs you may require additional treatment by physician or oral and maxillofacial surgeon.

_____I understand that an extraction may cause a fracture in the surrounding bone. Occasionally, the tooth to be extracted may be fused to the surrounding bone. In both situations, additional treatment is necessary. Bone fragments called “spicules” may arise at the site following extraction and are generally easily removed.

_____ I understand that tooth fragments may be left in the extraction site following treatment due to the condition and position of the tooth/teeth. Generally, this causes no problems, but on rare occasions the fragments become infected and must be removed.

_____I understand that the nerves that control sensations in my teeth, gums, tongue, lips and chin run through my jaw. Depending on the tooth to be extracted (particularly lower teeth or third molars), occasionally it may be impossible to avoid touching, moving, stretching, bruising, cutting or severing a nerve. This could change the normal sensations in any of these areas, causing itching, tingling or burning, or the loss of all sensation including numbness of the chin, cheeks, lips, gums, or tongue, including loss of taste. These changes could last from several weeks to several months or in some cases, indefinitely.

Consequences if No Treatment is Administered, Not Limited to the Following:

_____I understand that if no treatment is performed, I may continue to experience symptoms, which could include pain and/or infection, deterioration of the bone surrounding my teeth, changes to my bite, discomfort in my jaw joint, and possibly the premature loss of other teeth.

Alternative Treatments if Extraction is Not the Only Solution, Not Limited to the Following:

_____I understand that depending on my diagnosis, alternatives to extraction may exist which involve other disciplines in dentistry. I asked my dentist about them and their respective costs. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs.

Alternatives discussed:

_____Refering to see specialists for second opinion and treatment

_____Root canal therapy, build up, crown for tooth#_____

_____Crown lengthening for tooth _____

_____After extraction: doing nothing, bridgework, dentures, bone graft, implant, abutment, crown

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

Check only one of the boxes below that applies to you:

□ **Yes**, I have been given the opportunity to ask questions and I give my consent for the extraction of tooth number(s) #_____ as described above by Dr. Nguyen and associates.
OR
□ **No**, I refuse to give my consent for the proposed treatment(s) as described above and understand the potential consequences associated with this refusal.

_____I have been given the opportunity to ask questions and give my consent for the proposed treatment as described above.

_____ _____

Patient's (or Patient's Representative's) Signature **Date**

I attest that I have discussed the risks, benefits, consequences, and alternatives to bone and gingival grafting with the patient, who has had the opportunity to ask questions, and I believe my patient understands what has been explained and willingly consents to the treatments noted herein. 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.

Dentist's Signature: _____ Date:_____

Witness' (Staff"s) Signature:_____ Date:_____