Consent for Extraction(s)

I hereby authorize Dr. Wiesenmayer to perform the following treatment or surgical procedure_____, and I understand that this is an **elective, urgent, or emergency** procedure (circle one).

Alternative Treatments include_____.

I have been informed that the risks to my health if this procedure is not performed include, but are not limited to pain, infection, cyst formation, loss of bone around teeth causing their loss, and an increased risk of complications if surgery is postponed.

Potential Risks and Complications:

1. Postoperative discomfort and swelling that may necessitate several days of home recuperation.
2. Restricted mouth opening for several days or weeks.
3. Prolonged bleeding.
4. Nausea and vomiting (usually associated with medications prescribed for pain).
5. Postoperative infection requiring additional treatment.
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery.
7. Damage to adjacent teeth, fillings, and crowns.
8. Stretching of the corners of the mouth with resulting cracking and bruising.
9. Opening into the maxillary nasal sinus or nose requiring additional surgery.
10. Prolonged drowsiness.
11. Change in occlusion and temporal-mandibular joint difficulty.
12. Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months, or in remote instances, be permanent.
13. Fracture of the jaw.

I consent to the administration of **local anesthesia, nitrous oxide analgesia** or **oral sedation** in connection to the procedure referred to above (circle all that apply). Drugs given at the time of surgery for sedative purposes or control of pain following the surgery may cause drowsiness and a lack of awareness or coordination.

I certify that I have read the above and fully understand this consent for treatment. I understand that a perfect result cannot be guaranteed. If unexpected problems arise during the procedure, the doctor has my permission to do what is deemed necessary to correct the condition. I am aware of the fee(s) associated with this treatment and am responsible for any and all payments not covered by my insurance.

Patient Signature _____ Date _____
Doctor Signature _____ Witness Signature_____