

# Anthony J. Hornaday, D.D.S.

Oral and Maxillofacial Surgery

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## CONSENT FOR EXTRACTION OF TEETH

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Patient Name: <<patient\_first\_name>> <<patient\_last\_name>> Date: <<current\_date>>

It is required that all patients read and sign consent prior to any treatment. In order for you to give your consent to treatment we feel strongly that you, as the patient, should be given as much information as possible regarding that treatment. We have found that our best patients are our most informed patients. This information is not meant to alarm you, but rather allow you to make an informed decision. We also feel that you should have an opportunity to ask questions and receive satisfactory answers to those questions. We ask that you please take your time and read the following form completely.

Extraction of teeth is an *irreversible* process, and whether routine or difficult, is a surgical procedure. As in any surgery, there are some potential risks and complications. These include, but are not limited to, the following:

1. Swelling and/or bruising and discomfort in the surgery area.
2. Stretching of the corners of the mouth resulting in cracking or bruising.
3. Possible infection requiring additional treatment, including hospitalization.
4. Injury to nerves: In the lower jaw there is a nerve canal for a nerve (inferior alveolar nerve) that supplies feeling to the lower lip, chin, tongue, teeth, gingiva (gums), and cheek. There is also a nerve (lingual nerve) that lies outside the lower jaw that supplies feeling to the tongue. There is a possibility that these nerves could be bumped, bruised, cut, or damaged during the removal of teeth, especially 3<sup>rd</sup> molars (wisdom teeth). If injury were to occur to any one of the previously mentioned nerves, numbness of the lower lip, chin, tongue, teeth, gingiva (gums), and/or cheek could occur. Injury to these nerves can also cause pain (dysesthesia) which can persist indefinitely. *Usually* this is temporary, but it **could be permanent**. Numbness of the tongue would also result in loss of taste.
5. Dry socket (Alveolar Osteitis) – failure of a normal blood clot to form in the extraction site causing jaw pain, usually requiring additional care.
6. Possible damage to adjacent teeth, especially those with large fillings or crowns, requiring replacement of the filling or crown, extraction, or root canal therapy of the tooth/teeth involved.
7. Injury to the temporomandibular joint (TMJ): Removal of teeth may produce pain, clicking, and/or limitation of motion (Trismus). If you have a preexisting TMJ disorder Dr. Hornaday should be notified **before** surgery. Removal of teeth can aggravate a preexisting problem with your TMJ even with the gentlest of care. If a problem with your TMJ should occur further treatment may be necessary.
8. Heavy bleeding. This may require hospitalization and/or a general anesthetic to resolve.
9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.
10. Incomplete removal of tooth fragments: to avoid injury to vital structures such as nerves, vessels, or sinus, small root tips may be left in place. Rarely, these fragments of tooth may require an additional procedure to remove if they become infected.

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Date: <<current\_date>>

11. Sinus involvement: the roots of upper back teeth are often close to the maxillary (upper jaw) sinus and sometimes a piece of the root or entire tooth can be displaced into the sinus. An opening from the mouth into the sinus and/or an infection can occur which may require additional surgical procedure(s) and/or hospitalization.
12. Jaw fracture - while quite rare, it is possible in difficult or deeply impacted teeth or in people with atrophic (small) mandibles (lower jaw). This would require wiring the jaws together and/or hospitalization for an open reduction and internal fixation (application of plates and screws) of the jaw.
13. Nausea and/or vomiting, usually due to medications.
14. Displacement of an upper tooth into a space behind the upper jaw called the infratemporal fossa. This may require hospitalization and a general anesthetic to remove.
15. Accidental swallowing of a tooth, filling, or other foreign material that may require X-Rays at the hospital to determine where the material lodged.
16. I understand when teeth are removed that a space is created. I understand that adjacent teeth either next to or opposing the space may migrate or supererupt into the space which may lead to their removal also if nothing is done to replace the extracted teeth.
17. I understand that no warranties or guarantees of any kind have been made to me or anyone about the results of my surgery or procedure(s). I have been given adequate opportunity to read this entire form and to ask any questions about my surgery or procedure(s) before signing this form. I understand that it is my responsibility to inform my doctor if I wish to try another method of treatment to keep my tooth/teeth rather than undergo surgical intervention. I have been informed of the reason for my surgery, the risks involved, and possible alternate methods of treatment, if any, and I elect to undergo the treatment Dr. Hornaday has proposed.
18. I understand and agree that this consent form is valid for all future procedures unless the content changes, at which time I will be given an updated consent form.
19. I understand that I will be asked to sign this consent form in a digital format and that the form I sign digitally is an exact duplicate of this form I just read.

While performing my dental surgery I recognize that my doctor may discover other or different conditions than expected. This may require different or additional procedures than those planned or may require termination of my surgery. I authorize Dr. Hornaday to perform such other procedures as he deems medically and/or surgically necessary in his professional judgment or to stop my procedure.

I consent to the administration of anesthetics and medications as may be deemed necessary or advisable for my comfort, health, and safety. If general anesthesia is used, I understand that there may be soreness, redness, swelling, and/or bruising at or around the IV site or along the vein that may require additional treatment. Other rare complications of IV anesthesia may include allergic reaction to medications, respiratory problems that may require a breathing tube be placed, stroke, heart attack, heart failure, and/or death.

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I am also aware that oral sedation, intravenous (IV) sedation, general anesthesia, and many drugs are not recommended for use for women who are pregnant. I understand that it is my responsibility (or the responsibility of a parent or legal guardian of a female patient) to advise my doctor if I am pregnant or possibly could be pregnant.

I also have been informed by Dr. Hornaday that antibiotics can and may interfere with the effectiveness of birth control and that I can and may become pregnant if another form of contraception is not used. I also understand and have been informed that if antibiotics are used in my care I will need to use another form of contraception and should consult my medical doctor.

I have been made aware that certain medications, drugs, anesthetics and prescriptions that I may be given can cause drowsiness, and lack of awareness and coordination which also may be increased by the use of alcohol and other drugs. I understand that I should not use alcohol, operate a vehicle or other hazardous machinery, or make any legal decisions while under the influence of any medication, anesthesia, or prescription given by this office. I have been advised not to return to work while taking such medications, or until fully recovered from the effects of such medications, drugs, anesthetics and/or prescriptions. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am given sedative medication for my surgery, I agree not to drive myself to the appointment or home afterwards and will have a responsible adult drive me to the appointment and home and accompany me until I am fully recovered from the effects of the sedation.

I certify that I have read and fully understand the terms and words in the above consent and /or any verbal explanations given to me by my doctor and/or his assistants, and that I give my consent voluntarily.

Patient or Legal Guardian Signature Date: <<current\_date>>

Witness Signature Date: <<current\_date>>

Doctor Signature Date: <<current\_date>>