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INFORMED CONSENT

EXTRACTION

I understand that the extraction of one or more of my teeth includes certain risks and possible unsuccessful results. I agree to assume those risks. I also understand that this procedure can be performed by an oral surgeon (a dental specialist). Although great care and diligence will be exercised in this treatment, no promise or guarantees for desired results can be made or expected.

**Dental Extraction** involves removing one or more teeth, and may require sectioning the teeth or trimming the gum or bone.

**Benefits:** The proposed treatment should help to relieve your symptoms or prevent the development of other problems.

**Alternatives to Extraction:** Depending on my diagnosis, there may or may not be an alternative to extraction that involves other types of dental care. My tooth (teeth) may be able to be saved by root canal therapy, crown restoration, gum treatment, etc. If there is an alternative to this procedure, it has been explained to me and I have chosen the option of an extraction.

**Risks of Extraction:**

* I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure including extractions.
* The healing process may vary; no guarantees can be made.
* If unexpected difficulties occur during treatment, you may be referred to an oral surgeon, who is a specialist in dental surgery.
* You will receive a local anesthetic and/or medications which carry risks, side effects, and drug interactions.
* During and following treatment you may experience pain or discomfort, bleeding,

swelling, facial bruising (black and blue) in and around the surgical area, jaw joint pain or muscle spasm, cracking or bruising of the corners of the mouth, impact on speech, accidental swallowing of foreign matter, transient or permanent increased tooth looseness and tooth sensitivity to hot, cold, sweet or acidic foods.

* Extraction surgery may leave your jaw feeling stiff and sore and may make it difficult for you to open wide for several days or weeks.
* It is possible for an infection to occur in the extraction site and an antibiotic and/or other

procedures may be needed to treat the infection.

* Occasionally, 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 in healing.
* The instruments used in extracting a tooth may unavoidably cause loss or injury to adjacent teeth or dental restorations and soft tissue. Other complications include jaw fracture and swallowing or aspiration of teeth and restorations.
* Upper teeth have roots that may extend close to the sinuses. Removing these teeth may

temporarily leave a small opening into the sinuses, requiring additional treatment.

* Extraction may cause a fracture in the surrounding bone, or occasionally, the tooth to be

extracted may be fused to the surrounding bone, causing the surgical procedure to              become more complex and more costly.

* Small root fragments and/or bone fragments called “spicules” may break off from the tooth being extracted. Depending on their size and position, they may either be left to remain in the tooth socket, or they may become infected and require additional surgery for removal.
* Accidental swallowing of foreign matter.
* During surgery it may be impossible to avoid touching, moving stretching, or injuring the

nerves in my jaw that control sensations and functions in my lips, tongue, chin, teeth,

and mouth. This may result in nerve disturbances such as temporary or permanent

numbness, itching, burning, or tingling of the lip, tongue, chin, teeth and/or mouth

tissues.

* Extracted teeth that are not replaced may lead to the other teeth moving or drifting, creating spaces between the remaining teeth and making it difficult to impossible to replace them or straighten them later.
* Extracting the tooth may not relieve my symptoms and complications beyond that listed can occur that are unforeseen, complex and serious. These situations may require referral to other health professionals and may require hospitalization.. Other treatment or procedures maybe necessary. The exact duration of any complication cannot be determined, and they may be irreversible.

I understand that I will be responsible fees relating to any and all complication that may develop.

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**Consequences of No Treatment:** lack of treatment may lead to pain, infection, loss of teeth, and other medical risks.

**Females Only:** Antibiotics may interfere with the effectiveness of oral contraceptives. (birth control pills). Therefore, I understand that I will need to use some additional form of birth control.

**Acknowledgement:** I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays. I realize that in spite of the possible of the possible complication and risks, my recommended extraction/surgery is necessary.

**Informed consent:** I have been given the opportunity to ask any questions regarding the nature and purpose of an extraction and have received answers to my satisfaction. I also understand that any questions that I might have during treatment will be answered when I ask them. I voluntarily assume any and all possible risk of substantial harm, if any, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. I understand that I will be responsible fees relating to any and all complication that may develop. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Kaplan with associates or assistants of his (their) choice to render any treatment deemed necessary, desirable and/or advisable to my dental conditions.

\_\_\_\_I give my consent for the proposed extraction procedures as described above.

\_\_\_\_I refuse to give my consent for the proposed extraction procedures s described above. I have been informed of the potential consequences of my decision to refuse this treatment.

Patient Name:

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Patient’s signature Date

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