OWEN SOUND
DENTAL CLINIC

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Informed Consent for: Extraction/ Oral Surgery

The dentist has explained to me the proposed treatment and the anticipated results for treatment. I understand this is an elective procedure and that there are other forms of treatment available. The dentist has also explained to me the certain potential risks associated with this treatment.

Risks:

The Following are **Unlikely** Risks that may occur during and/ or after Extraction:

- Post-Operative infection requiring additional treatment
- Injury to adjacent teeth and fillings
- Post-Operative discomfort, swelling and bleeding that may necessitate several days of recuperation
- A small piece of root left in the jaw when removal would require extensive surgery
- Dry socket (the loss of blood clot at the base of the Extraction site) requiring additional treatment
- Removal of hard and/or soft tissue around the tooth for complete removal of tooth.

Other Treatment Options:

The following are other treatment options that might be possible:

- No Treatment at all, with risk of continued pain/ recurrent infection
- Waiting for more definitive development of symptoms

Unforeseen conditions may arise during the treatment that requires a different procedure than set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their personal judgement, are deemed necessary.

I understand that the medications, prescriptions, drugs and anaesthetics (freezing), for this treatment may cause drowsiness, and or lack of awareness and coordination. I understand that a perfect result is not guaranteed.

I have had an opportunity to discuss and ask any questions to my Dentist (service provider), and I am satisfied with the answers that I have received.

I therefore Consent to this procedure.

Date: _____ Tooth#: _____

Patient Name: _____ Patient Signature: _____

Prognosis: _____ Dentist: _____