Consent to Tooth Extraction

Patient Name: _____ Date:_____

Please review the following consent. You will be required to sign this form prior to the initiation of treatment.

This is my consent to the oral surgery procedures indicated and any other procedures deemed necessary in conjunction with the extraction performed by Qun Zeng D.D.S or any associate doctor with whom he works.

Oral surgery has a very high degree of success, however, such results cannot be guaranteed. Occasionally, complications occur including but not limited to swelling, pain, numbness or tingling of the lip or tongue, which very rarely can be permanent, damage to near by teeth, bruising, infection, prolonged bleeding, dry socket, parts of the root may break off and may or may not be removed, openings into the sinus cavity, jaw dislocation or fracture or TMJ. I understand that it is my responsibility to report any of these symptoms to the doctor immediately. At times, the doctor will prescribe pain medication and antibiotics. I understand that antibiotics can reduce the effectiveness of birth control pills. I also understand that medications for discomfort may cause drowsiness, which can be increased by the use of alcohol or other drugs, I am advised against the use of alcohol or the operation of any vehicle or hazardous device while taking such medications. Also, certain medications may cause hives and intestinal problems. If any of these reactions occur, I am to call the doctor immediately. I understand that it is my responsibility to report any changes in my medical history to the doctor prior to surgery.

If there is anything that you do not understand about the procedure and potential risks, or if you still have any questions after reading this form, please ask the doctor. If you have no questions and agree to the recommended extraction(s), please sign below.

_____ Knowing the risks associated with this procedure, I consent to allow Dr. Zeng
pt initials to remove _____

_____ I have been given the opportunity to ask questions about the procedure and am
pt initials fully satisfied with the answers I have received.

_____ _____
Patient signature Date

_____
Witness