Tooth Extraction & Ridge Preservation

PATIENT'S NAME (PRINTED) _____

Area treated: _____

Tooth Extraction - I understand tooth is hopeless/ non-restorable and needs to be removed. Consequences of losing a tooth is esthetic compromise, food impact, drifting of neighboring and opposing teeth into missing space, loss of supporting bone and soft tissue. Dental implant or bridge is recommended to replace a missing tooth afterwards.

Ridge Preservation (Bone Graft and membrane) – This procedure is recommended in esthetic areas (anteriors/canines/premolars) and where bone is thin around a tooth. Supporting bone will resorb and shrink once it loses its function of supporting a tooth. Shrinkage will still occur, but bone graft/membrane will minimize shrinkage so we can maintain as much bone/tissue volume as possible. Bone graft and membrane will try to maintain a space where new bone can grow inside. Bone grafts come from a donor and it has been thoroughly processed into a sterilized vial. Collagen membrane will be placed to cover bone graft material. Membrane will act as a barrier to keep gum tissue away so bone can grow into the socket. Both bone graft and membrane are resorbable. However, in certain cases, non-resorbable membranes may be used for better support, which require removal at a separate visit.

I understand there are certain associated risks and normal complications which may occur despite all the efforts to the contrary. The common risks are (but not limited to):

1. Drug reactions and side effects
2. Damage to adjacent teeth or filling
3. Post-operative infection
4. Post-operative bleeding that may require treatment
5. Possibility a small fragment of root will be left in the jaw when its removal would require further surgery
6. Delayed healing (Dry socket) necessitating frequent post-operative care
7. Possible involvement of the sinus during removal of upper molars, which may require additional treatment surgical repair at a later date
8. Possible involvement of the nerve within the lower jaw during the removal of the lower molars resulting in temporary but possible permanent tingling or numbness of the lower lip, chin, or tongue on the operated side

I give permission for the use of local anesthetic. The possible side effects of local anesthetics are prolonged or permanent numbness of the lips, cheeks, or gums, rapid heart rate, dizziness, vomiting, allergic reactions, and reactions with other drugs that I am taking.

I understand that there may be alternatives to the extraction of teeth, and after the doctors explanation, I have chosen extraction. I further understand that this procedure can also be performed by an Oral surgeon and prefer that this treatment be rendered in this office.

I also understand that the healing can be effected by my underlying medical or dental condition, dietary and nutritional problems, smoking, alcohol, inadequate oral hygiene, inadequate follow up

with a dentist or dental hygienist, and the medications that I am taking. I understand that my diligence in performing personal daily care recommended by my dentist and hygienist and taking prescribed medications are important to the ultimate health of my gums, teeth, and crowns.

I understand the risks of driving, operating hazardous equipment, and drinking alcohol while taking certain prescription medication. I agree to cooperate completely with the doctor while under his/her care realizing that any lack of the same could contribute to less than optimum results. I have had adequate opportunity to discuss my past medical and health history.

I hereby acknowledge I have completely read the foregoing; have discussed any questions or concerns, which I may have regarding my proposed surgery/dental treatment, and have been given satisfactory answers. I understand what is to be done, and that there is no warranty or guarantee as to any result and /or cure. I accept this treatment with the understanding that I will hold the doctor harmless for any complications resulting in this treatment.

Patient signature: _____

Witness signature: _____

Dentist signature: _____

Date: _____