

## CONSENT FOR ORAL SURGERY: EXTRACTION AND/OR BONE GRAFTING

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

1. Swelling and/or bruising and discomfort in the surgery area.
2. Stretching of the corners of the mouth resulting in cracking and bruising.
3. Possible infection requiring further treatment.
4. Allergic reaction to one of the medications used.
5. Abnormal connection between the mouth (upper teeth) and sinus. The roots of upper back teeth are often close to the sinus and sometimes an opening may occur requiring further treatment.
6. Numbness or altered sensation in the teeth, lip, tongue and chin due to trauma to the nerve of the lower jaw. Sensation most often returns to normal, but in rare cases, the loss may be permanent.
7. "Dry-Socket" – jaw pain beginning a few days after surgery, usually requiring additional care. It is more common from lower extractions.
8. Bleeding – significant bleeding is not common, but persistent oozing can be expected for several hours.
9. Need for augmentation of existing bone (bone grafting) may also be needed to complete treatment. Grafting materials are collected from volunteer donors whose legal next-of-kin have given written permission for donation. Each individual's donor history is carefully reviewed to reduce any possibility of disease transmission and ensure product integrity. These products are made from donors found non-reactive to serological tests from Hepatitis B surface antigens, HTLV-III antibody and syphilis. These products may be used in any situation where the doctor believes that a bone and/or soft tissue graft will promote healing or facilitate applicable surgical procedures. These procedures have been determined to be properly prepared in accordance with the current guidelines of the FDA.

I authorize the use of human prepared bone and/or soft tissue. I approve the use of photographs, x-ray films and any other documentation of my care for the advancement of Implant Dentistry. I approve my modification in design, materials or care if, in the doctor's professional opinion, such modification is in my best interest. I have read and understand the above, and have had my questions answered. I understand that there can be no warranty as to the outcome of treatment, and I give my consent to the surgery.

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Patient (or legal guardian)

Date

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Doctor

Date