



**INFORMED CONSENT FOR DENTAL  
SURGERY (EXTRACTIONS)**

After careful oral examination, the treating dentist at Advanced Dental Services of Jacksonville has advised me that tooth/teeth extractions is/are required. I hereby give consent to Dr. Andrew Maples and/or Dr. Brian Maples to complete this recommended treatment.

The treating dentist has fully explained to me the purpose of the operation/procedure and has also informed me of all expected benefits and complications (from known and unknown causes) associated with the recommended treatment. The discomforts and risks that may arise have been thoroughly explained. The risks discussed include, but are not limited to the following:

- Injury of adjacent teeth and/or fillings.
- Loose teeth.
- Removal of alveolar bone along with an extracted tooth.
- Fractured roots and the possibility of leaving a portion of the root in the jaw.
- Nerve damage after mandibular surgery resulting in temporary or permanent numbness of the lower lip, chin, or tongue.
- Damage to anatomical structures (i.e. blood vessels, nerves, glands, etc.).
- Fusion of teeth resulting in the removal of two/multiple teeth.
- Extraction of adjacent teeth with diminished bone support.
- Dislodged tooth into the maxillary sinus or soft tissue.
- An opening into the sinus or sinus infection.
- Fractured jaw.
- Injury to a tooth bud (forming permanent tooth).
- Bleeding.
- Infection.
- Dry Socket.
- An unresolved infection.
- Temporomandibular joint trauma.
- Severe pain or inflammatory swelling (edema).
- Postoperative stiffness or limited jaw opening.
- Small, loose bony spicules (sequestrum) or bony irregularities.

I understand that during the course of the procedure unforeseen conditions may arise which necessitate procedures different from those contemplated. I therefore consent to the performance of additional procedures which the above-named dentist may consider necessary.

The possible treatment alternatives (including no treatment) have been reviewed. If I don't have the procedure completed, my condition may stay the same, improve, or get worse. It is the doctor's opinion that the proposed procedure is a better option for me. The treating dentist has also explained the consequences of not having the extraction completed.

The practice of dentistry and surgery is not an exact science. Although good results are expected, the doctor has not given me any guarantee that the proposed treatment will be successful, will be to my complete satisfaction, or that it will last for any specific length of time. Due to individual patient differences, there is always a risk of failure, need for more treatment, or worsening of my present condition despite careful treatment.

The benefits, risks, and complications associated with local anesthesia and sedation have been thoroughly reviewed with me. The risks discussed include, but are not limited to: partial or complete paralysis of facial nerve(s), hematoma (a swelling that contains blood), fracturing of the anesthetic needle, temporary or permanent numbness, allergic reaction, drowsiness, nausea, vomiting, dizziness, lack of coordination, miscarriage, cardiac conditions, decreased heart rate, and depressed breathing. If applicable, I will arrange for someone to drive me home from the office after I have received oral sedation, and to have someone watch me closely for 10 hours after my dental appointment to observe for side effects such as difficulty breathing or passing out.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods which I am allergic. I will follow any and all instructions as explained and directed to me, and permit all required diagnostic procedures. I have had an opportunity to discuss my past medical and health history including any serious problems and/or injury with the doctor.

I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I confirm that I have read and fully understand the above and I agree to cooperate completely with the doctor's recommendations while receiving care at Advanced Dental Services of Jacksonville.

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE