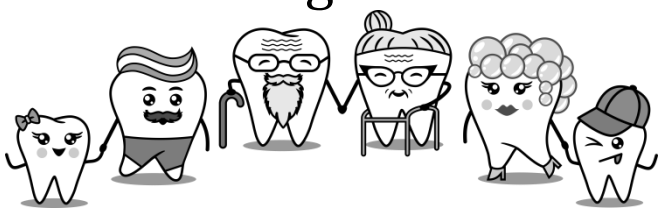
Dr Ivana Bugwandeen Inc



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Discussion and Consent for Extraction

Patient's Name: _____ _____ _____

Last **First** **Initial**

Date of Birth: _____

I am being provided with this information and consent form so I may better understand the treatment recommended for me.
Before beginning, I wish to be provided with sufficient information, in a way I can understand, to make a well informed decision regarding my proposed treatment.
I understand that I may ask any questions I wish, and that it is better to ask them before treatment begins than to wonder about it after treatment has started.

Nature of Extraction

It has been recommended that I have the following tooth (teeth) extracted: _____
This recommendation is based on visual examination(s), on any X-rays, models, photos and other diagnostic tests taken, and on my dentist's knowledge of my medical and dental history. My needs and desires have also been taken into consideration.
The extraction is necessary because of:
☐ Pain ☐ Infection ☐ Periodontal (gum) disease ☐ Decay ☐ Broken Tooth/Teeth ☐ Tooth is not restorable
☐ Other: _____
The intended benefit of extraction is to relieve my current symptoms and/or to permit me to continue with any additional treatment my dentist has proposed.
The prognosis, or likelihood of success, of this extraction is _____

Alternatives to Extraction

Depending on my diagnosis, there may or may not be an alternative to extraction that involves other types of dental care.
☐ Tooth # _____can be restored/retained by:
☐ Root canal therapy ☐ Filling ☐ Crown ☐ Gum treatment, or ☐ Other treatment (specify):_____
☐ Tooth # _____cannot be restored. Extraction is the only reasonable treatment option
☐ Tooth #_____ should not be restored. Reason:_____

☐ Initial

I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including _____

Risks of Extraction

I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure, including extractions. I understand that during and following treatment, I may experience pain or discomfort, bleeding, swelling, bruising, and stiff jaws, all of which may last for several days. I understand that it is possible for an infection to occur in the extraction site and that I may need antibiotics and/or other procedures to treat the infection. I understand that less common complications include: dry socket (lost blood clot); loss or loosening of dental restorations; loss or injury to adjacent teeth and soft tissues; jaw fractures; sinus exposure (upper teeth); inferior alveolar nerve damage (lower teeth); swallowing or aspiration of teeth and restorations. I understand that small root fragments may break of from the tooth being extracted. Depending on their size and position, they may either be left to remain in the jaw or may require additional surgery for removal.

☐ Initial

I understand that extracting the tooth may not relieve my symptoms and that complications may occur. Other treatment or procedures may be necessary.

Other foreseeable risks not stated above include: _____
I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about, including _____

Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including antibiotics, drugs, or other medications I am currently taking, as well as those to which I am allergic. I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including X-rays.
I realize that in spite of the possible complications and risks, my recommended extraction is necessary. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the treatment.

I, _____, have received information about the proposed treatment. I have discussed my treatment with **Dr. Bugwandeen** and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risks of refusing treatment.
I wish to proceed with the recommended treatment.

☐ Initial

I understand this treatment can also be performed by an oral surgeon (dental specialist). I understand the risks and elect to have this procedure performed by **Dr.Bugwandeen** . I understand that if any unexpected difficulties occur during treatment, I may be referred to an oral surgeon for further care.

Signed: _____ Date: _____
Patient or Guardian

Signed: _____ Date: _____
Treating Dentist

Signed: _____ Date: _____
Witness