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Consent for exposure of impacted (non-erupted) tooth

Patient Name: _____

I have been diagnosed with an impacted (non-erupted) tooth. I understand that this tooth will not erupt into a functional and appropriate position without treatment. I have been advised that surgical uncovering (exposure) of this tooth (with or without placement of and orthodontic attachment) and subsequent orthodontic traction is necessary to achieve an appropriate and functional position for the tooth.

The procedure, its attendant risks, expected post-operative course, and alternatives to this treatment have been described. I understand the risks to include, but not strictly limited to, the following: bleeding, pain, infection, damage to adjacent teeth, development of periodontal defects, altered or loss of sensation (feeling) in the area of surgery, attachment (bracket) loss, aspiration or swallowing of the attachment, and the possible need for additional procedures in the future. I further understand that successful placement of an orthodontic attachment does not guarantee the successful orthodontic positioning of the involved tooth. Patient Initials: _____

I understand that following this procedure, orthodontic treatment will be required to bring the tooth from it's present position into the position desired. This may take a variable period of time. In the event the tooth cannot be orthodontically assisted into the desired position, the attachment and\or the tooth will need to be removed and a prosthetic (artificial) replacement constructed.
I acknowledge that I have read this consent and have had all my questions answered to my satisfaction. I understand the tooth (teeth) to be treated is (are):

_____

Signatures:

Patient: _____ Date: _____

Parent or Guardian: _____
(patient is a minor or is legally incompetent to give consent)

Doctor: _____