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Consent for Extraction of Wisdom Teeth

Patient Name: _____

The reasons for removal of my wisdom tooth or teeth have been fully explained to me by my referring dentist and/or by Dr Cary. I understand the benefits from surgery, alternatives to this procedure, as well as the possible adverse consequences of surgery. I have been given opportunity to ask questions regarding my particular case, the planned surgery, its attendant risks and expected benefits, as well as the expected post-operative course of healing and recovery from surgery. My questions have been answered completely and to my satisfaction.

I realize that a variable amount of swelling and discomfort will occur following the removal of wisdom teeth, and that these things are usually a normal post-operative occurrence. The following are other possible complications which have been explained to me:

Infection, bleeding, injury to adjacent teeth or dental restorations, injury to sinuses, temporomandibular joint (TMJ-jaw joint) strain or injury, changes in feeling or loss of feeling to the chin, lip, tongue ,teeth, or gum tissues resulting from injury to nerves (temporary or possibly permanent), fracture of the jaw, development of bone and/or gum defects as relates to poor healing affecting the adjacent teeth, prolonged wound healing, and other less foreseeable problems.

Wisdom teeth to be removed: Upper right _____ Upper left _____ Lower right _____ Lower left _____

Patient initials:_____

I understand that in the event of the development of any of these complications, additional treatment or surgery may be required. I understand that a variable period of time postoperatively will be needed for healing and that my activities will need to be altered accordingly.

I acknowledge that I have read and understand the terms of this consent.

Signatures: _____
Patient (parent if patient is a minor or unable to provide legal consent)

_____
Doctor Date: