

Periodontal Associates

OF MEMPHIS

Periodontal, Laser and Dental Implant Therapy

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INFORMED CONSENT FOR EXTRACTION WITH LOCAL ANESTHESIA

Patient's name _____

An explanation of your need for tooth removal was discussed with you at your consultation. We obtained your verbal consent to undergo this procedure. Please read this document which restates issues we discussed and provide the appropriate signature on the last page. Please ask for clarification of anything you do not understand.

DIAGNOSIS: I have been informed of the need for dental extraction (the removal of a tooth or several teeth). The reasons for this extraction have been explained to me.

SUGGESTED TREATMENT: It has been suggested that the tooth/teeth circled below be removed:

Upper Right

Upper Left

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Lower Right

Lower Left

DESCRIPTION OF THE PROCEDURE: After anesthetics have numbed the area to be operated, extraction will be accomplished by either the removal of the tooth/teeth or by surgical reflection of gum, possible removal of some bone around the tooth/teeth, and possible sectioning of tooth roots to facilitate removal of the tooth/teeth. After the extraction, tooth socket(s) (hole in jawbone left by tooth removal) will be inspected, possibly cleansed of debris or infected soft tissue, and when indicated, this soft tissue may be submitted for histological examination to determine if pathology was present. Finally, the gum and socket or gum tissue may be sutured and measures will be taken to reduce bleeding from the extracted area(s) after this procedure.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and after thorough deliberation, I give my consent for the performance of any and all procedures related to tooth extraction as presented to me during the consultation and treatment plan presentation by the doctor or as described in this document.

Patient's Signature	Date	Patient's Name
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Parent or Guardian Signature	Date	Relationship to Patient
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Witness Signature	Date	
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Active Member
 American Academy of Periodontology
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