

Consent for Tooth Extraction and the Simultaneous Use of Bone Grafting

Babak Noohi, DDS, MS, PLLC

CAPITOL HILL DENTISTRY

I hereby authorize Doctor BABAK NOOHI, and whomever he may designate as his assistant(s), to perform the following treatment and/or surgery upon, _____.
(Name of patient)

DIAGNOSIS

I have been informed of the need for surgical dental extraction (the removal of a tooth or several teeth). The reasons for this extraction have been explained to me. The tooth/teeth to be removed are checked below:

Upper Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Left

Tooth/teeth numbers:_____.

I have been given the option to preserve the extracted socket with bone graft and membrane, in order to preserve the alveolar bone from getting excessively resorbed. I have also been given the option to use Biologic agents along with the bone graft for additional charges (which may not be covered by my insurance).

TREATMENT PROCEDURES

- Oral Hygiene/disease prevention Microbial Cultures
- Chemical pocket irrigation and antibiotic therapy
- Biopsy of tissue for microscopic evaluation (if indicated)
- Periodontal Surgery (gingivoplasty; flap surgery with or without osseous contouring; osseous/alloplastic grafts; GTR; soft tissues grafts; frenectomy).
- Extraction of teeth or roots as determine during surgery
- Guided Bone Regeneration (Bone Graft & Biologic Membrane)
- Biologic Agents (Recombinant growth factors)
- Nitrous oxide, oral sedation (IF requested)

ALTERNATIVES

Further, I have been informed that possible, alternatives to the above treatment include:

- Maintenance therapy only
- Other: **“extraction only” and “doing nothing and maintenance”.**

NON-TREATMENT RISKS

I further understand that if no treatment is rendered the risks to my dental health include, but are not limited to, the following:

- Premature loss of teeth
- Gum recession
- Halitosis (bad breath)
- Loosening of teeth
- Abscesses (gum boils) or Cyst formation
- Tumor formation (e.g. ameloblastoma)
- Tooth drifting, flaring or tooth movement
- Further deepening of periodontal and/ or pus pockets
- Deteriorating functional abilities

TREATMENT RISKS

Risks of the treatment include, but are not limited to:

- Swelling
- Pain
- Infection
- Tooth mobility
- Tooth sensitivity to hot and/ or cold



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- Exposure of margins of crowns (caps) and / or root surfaces
- Phonetic interferences (difficulty with speech)
- Food impaction and spaces between teeth
- Temporary restricted mouth opening
- Numbness of jaw or gum (mainly associated with the lower jaw surgeries)
- Root resorption
- Failure of regeneration (graft) or
- Periodontal problems (pocket on the distal of the 2nd molar)
- Fracture of the maxillary (upper) tuberosity
- Fracture of the mandible (lower jaw)
- Other i.e.,

CONSENT TO UNFORSEEN CONDITIONS DURING SURGERY

If any other unforeseen condition should arise in the course of treatment calling for the Doctor's judgment for procedures, in addition to or different from those now contemplated, I further authorize the Doctor to do whatever he may deem advisable.

PHOTOGRAPHS

In furtherance of the progression of dentistry and the dental health of the public, I do hereby consent to photographs being taken of my oral and facial structures, and subsequent publication solely for the educational and scientific purposes. These photographs will be exposed in such a way as to protect my anonymity.

NO WARRANTY

No guarantee, warranty, or assurance has been given to me that the proposed treatment will be curative and/ or successful. Due to individual patient differences, a risk of failure, relapse, or worsening of my present periodontal condition may result despite treatment and may require retreatment and/or extraction of teeth.

It has been explained to me that the long term success of treatment requires my cooperation and performance of daily removal of bacterial deposits (plaque) from my teeth, as well as periodic periodontal maintenance therapy after the proposed treatment at a dental office.

I certify that I have read fully, understood and have had all of my questions answered so that I understand the above consent to treatment.

[Date]

[Printed name of patient, parent or Guardian]

[Signature of patient, parent or Guardian]

[Date]

[Signature of witness]

[Printed name of witness]

*Babak Noohi, D.D.S., M.S.
Prosthodontist*

