INFORMED CONSENT FOR TOOTH REMOVAL (EXTRACTION)

Dr. Esquivel has explained the benefits and risks of tooth removal to me. I understand that surgical extraction may be necessary. Referral to a specialist (oral surgeon) has been offered.I understand and accept the treatment recommended for me by Dr. Esquivel. I further understand that there may be some unwanted complications, some of which are listed below. No guarantees have been made or implied. Dr. Esquivel has discussed whether or not the tooth/teeth he has proposed be extracted are impacted by any degree. I understand that an impacted tooth may have begun to erupt in the wrong direction and may be blocked from fully erupting by the bone and adjacent teeth. I understand that allowing impact to remain may result in infection and / or a cyst formation; in which case, may destroy bone, damage the roots of adjacent teeth from pressure of the mal-positioned tooth/teeth and or create food trap which may result in decay. Alternative treatment(s) or the option of no treatment has been explained to me. I understand the risks of not having the extraction(s) performed, whether the tooth/teeth are impacted, partially impacted or not impacted at all. Risks include but are not limited to infection, swelling, pain, periodontal disease, malocclusion, and systemic disease. All of my questions have been addressed. Proposed fees have been explained to me, as have any third-party insurance benefits. I understand that third-party benefits may be different than discussed by Dr. Esquivel as they are not under control of this office.

Treatment risks/unwanted Consemiences may be, but are not limited to:

- Reaction to medication / anesthetic
- Temporary or permanent numbness or tingling of the lip, chin, tongue, or other areas
- Post treatment bleeding
- Post treatment infection
- Post treatment tissue swelling
- Root fragments may break; they may be left in jaw
- Sinus involvement when upper teeth are removed, which may require additional treatment
- Jaw or alveolar bone may fracture during tooth removal, which may require additional treatment
- Healing may be delayed and require additional treatment such as for a dry socket

a Sensitivity / pain

- Damage to adjacent teeth or restorations

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN TO ME VERBALLY, AS PER MY SIGNATURE BELOW CONSENT TO THE TREATMENT DESCRIBED IN THIS FORM.

X _____ _____ _____

Patient's Name: D.O.B: Tooth to be Extracted:

X _____ _____

Patients' / Parent's Signature: Witness:

X _____ _____

Doctor's Signature: Date: