Tooth Extraction Consent

Informed consent. The dentist fills the treatment details and explains them; the patient or their representative signs.

Clinic and clinician

HOSPITAL OR CLINIC

DENTIST NAME

REGISTRATION NO. (MEDICAL COUNCIL)

PATIENT ID / UHID

Patient

PATIENT FULL NAME

EMAIL

DATE OF BIRTH

GENDER

PHONE

Proposed treatment

TOOTH NUMBER(S)

TYPE

DATE

The tooth is removed under local anaesthetic. A surgical extraction may need a small cut in the gum and stitches. You will receive written after-care instructions.

Risks

Every treatment carries some risk. The common and the serious ones for this treatment include:

- Pain, swelling and bruising for a few days
- Dry socket (painful delayed healing)
- Numbness of lip, chin or tongue, usually temporary, rarely permanent
- Damage to nearby teeth or fillings
- Opening into the sinus with upper back teeth

RISKS SPECIFIC TO THIS PATIENT

Alternatives

- Root canal treatment, if the tooth can be saved
- No treatment, with risk of pain and infection

Your health

Do you take blood thinners or have a bleeding disorder?

◯ No ◯ Yes

Have you taken medicine for osteoporosis or cancer (e.g. bisphosphonates)?

○ No ○ Yes

ALLERGIES, CURRENT MEDICINES, OR DETAILS OF ANY "YES"

Consent

EXPLAINED TO ME IN

SIGNED BY

REPRESENTATIVE NAME (IF NOT PATIENT)

RELATIONSHIP

- The dentist has explained the treatment, its purpose, risks and alternatives in a language I understand, and answered my questions.
- I understand no result can be guaranteed.
- This consent covers only the treatment described. If an unexpected problem arises during it that puts life or health at immediate risk, the team may do what is needed to deal with it and will explain afterwards.
- I may withdraw this consent at any time before the treatment starts.

☐ I give my consent to the treatment described above.

Patient

SIGNATURE

PRINTED NAME

DATE

Dentist

SIGNATURE

PRINTED NAME

DATE