south shore pediatric dentistry

INFORMED CONSENT FOR DENTAL EXTRACTION

Dental extraction is the permanent, irreversible, removal of a primary (baby) or permanent (adult) tooth/teeth.

Common indications:

- pain, loss of function, decay, infected or abscessed tooth, non-restorable tooth, fractured tooth, orthodontic reasons (crowding), failure to erupt, ankylosis, ectopic eruption, pathological resorption, associated with dental cysts, impaction

Common procedures <u>may be needed after</u> tooth extraction:

- Space maintainers (for baby teeth)
- Orthodontic treatment (for mixed dentition, permanent dentition)
- Fixed prosthodontic treatment (for adult teeth): implants, bridge (more tooth structure loss)

Potential benefits:

- relieve pain, eliminate source of infection, facilitate eruption of permanent teeth, enhance favorable result of orthodontic treatment, prevent dental diseases

Common potential risks/complications:

- Swelling, bleeding, bruising in the treatment area
- Traumatic lesions (due to post-op anesthesia: lips/cheeks/tongue/gum biting)
- Stretching of the corner of the mouth
- Aspiration (swallowing of extracted tooth)
- Injury to adjacent teeth and fillings
- Fractured tooth
- A small piece of root may be left in the jaw when removal would require extensive surgery

Less common potential risks/complications:

- Restricted opening for several days or weeks with possible dislocation of the temporomandibular (TMJ) joint
- Opening of the sinus requiring additional surgery
- Post-operative infection requiring additional treatment (dry-socket, cellulitis)
- Injury to a nerve resulting in numbness/ tingling of the chin, lip, cheeks, gums, tongue on the treatment area; this could persist for several days, weeks, months, or in rare cases, permanently
- In rare circumstances, cardiac arrest or breakage of the jaw
- During the course of surgery unforeseen conditions may occur which necessitate modifying or discontinuing the planned procedure

Alternative treatment options:

- No treatment which may lead to other serious conditions
- Root canal treatment/ pulptomy/ pulpectomy/ stainless steel crowns/ porcelain fused metal crowns
- Referral to oral surgeon

I am the parent/ legal guardian of _____
(Patient's name)

I hereby authorize Dr. Sally Hua and Associates to perform the following procedure in conjunction to dental restorative treatment: **extraction of tooth/ teeth:** _____

I have carefully read the printed material on this form. My signature on this form affirms that I fully understand this form, have had the opportunity to have questions answered to my satisfaction and authorize the procedure listed above.

Parent/ Legal Guardian Name: _____

Signature: **Date:**