INFORMATION & INFORMED CONSENT · SURGICAL DENTISTRY

CD-C18

Tooth Extraction

Please read this form carefully before your treatment. It explains what is involved, the benefits, the risks and your options. Ask your dentist about anything you do not understand. You do not have to sign until you are ready.

PATIENT DETAILS

PATIENT NAME

DATE OF BIRTH

TOOTH / TEETH TO BE REMOVED

TREATING DENTIST

CLINIC

01 About the treatment

A tooth extraction removes a tooth that is badly decayed, broken, infected, loose from gum disease, or needed for orthodontic space. After local anaesthetic, the tooth is loosened and removed. Some teeth need a surgical extraction, where a small cut is made in the gum, a little bone is removed or the tooth is divided, and stitches are placed.

EXPECTED BENEFITS

- Removes the source of pain or infection
- Prevents spread of infection to other teeth and tissues

ALTERNATIVES

- No treatment
- Root canal treatment and a crown
- Large filling or crown
- Periodontal treatment
- Referral to an oral surgeon

02 Risks and possible complications

All dental treatment carries some risk. Most complications are uncommon and manageable, but you should know about them before deciding. Risks specific to you, including those relating to your medical history, have been discussed with you.

- **Local anaesthetic.** Numbness usually wears off within 2 to 5 hours. Bruising or tenderness at the injection site, temporary jaw stiffness or a racing heartbeat can occur. Rarely, an injection touches a nerve and causes numbness or tingling that lasts weeks or longer, or an allergic reaction occurs.
- **Pain, swelling and bruising** are expected and usually peak 2 to 3 days after surgery, then settle over 7 to 10 days.
- **Bleeding.** Oozing for up to 24 hours is normal. Prolonged bleeding is uncommon and is more likely if you take blood thinners.
- **Infection** may require antibiotics, drainage or further treatment.
- **Limited mouth opening and jaw stiffness** for several days.
- **Damage to neighbouring teeth, fillings or crowns** during surgery.

- **Nerve injury (lower jaw).** Nerves supplying the lower lip, chin, tongue and teeth lie close to the lower back teeth. Bruising or injury can cause numbness, tingling or altered taste. This is usually temporary but in rare cases is permanent.
- **Sinus involvement (upper jaw).** Upper back teeth lie close to the maxillary sinus. An opening between the mouth and sinus can occur, which may need further treatment to close. Sinus infection or congestion can also occur.
- **Dry socket** (painful loss of the blood clot) in a small percentage of extractions, more often lower back teeth and in smokers.
- **Root fragments** may break and occasionally be left in place if removal would cause more harm than leaving them.
- **Jaw fracture** is very rare.

03 Your acknowledgement

Tick each box to confirm you understand and agree.

- ☐ I understand that a gap will be left and that options to replace the tooth (implant, bridge or denture) have been discussed.
- ☐ I have read this form, or it has been read to me, and I understand it.
- ☐ The dentist has explained the proposed treatment, why it is recommended, the expected benefits, the material risks and the reasonable alternatives, including no treatment.
- ☐ I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.
- ☐ I understand that dentistry is not an exact science and that no guarantee has been given about the outcome or how long treatment will last.
- ☐ I have given the dentist a complete and accurate medical history, including medicines, supplements, allergies and pregnancy (if applicable), and I will tell the clinic of any changes.
- ☐ I understand that unforeseen findings during treatment may require a change in plan, and that the dentist will discuss this with me where practical.
- ☐ I have received a written estimate of fees. I understand that fees may change if the treatment plan changes, and that health fund rebates are my responsibility to confirm.
- ☐ I consent to clinical photographs, X-rays and scans being taken and kept in my record. These will not be used for any other purpose without my separate written consent.
- ☐ I understand that I may withdraw my consent at any time before or during treatment.

04 Financial consent

ESTIMATED FEE ($) _____ ITEM NUMBERS / QUOTE REFERENCE _____

05 Consent

I, the undersigned, consent to **Tooth Extraction** as described above, and to the administration of any local anaesthetic or other medicines needed for this treatment.

Patient (or parent / guardian / substitute decision-maker)

FULL NAME _____ SIGNATURE _____ DATE _____

Dentist

I have explained the treatment, risks, benefits and alternatives, and answered the patient's questions.

NAME _____ SIGNATURE _____ DATE _____

Interpreter (if used)

NAME / LANGUAGE _____ SIGNATURE _____ DATE _____