Consent form for extraction of teeth

Proposed procedure:

Surgical extraction of:	Lower right wisdom tooth	□
(local anaesthetic)	Lower left wisdom tooth	□
	Upper right wisdom tooth	□
	Upper left wisdom tooth	□
	Other teeth…….....	□

Reason for the procedure:

Recurrent pain, swelling or infection	□
Decayed tooth or adjacent tooth	□
Other pathology	□
Other reason ……	□

Possible risks resulting from the procedure:

Pain, swelling, stitches, bruising, bleeding, infection	□
Risk of lip and chin numbness or altered sensation	□
Risk of tongue numbness or altered sensation/ taste	□
Risk of communication with air sinus	□
Stiffness of the jaw	□
Damage to surrounding teeth	□
Other ……..	□

Dentist signature:

Name: Dr Y. Szyszko

I confirm that the reasons for performing the procedure and the risks involved have been explained to me and I have had a chance to ask questions.
I consent to the above procedure.

Patient signature: **Date:**

Patient name: **Date of Birth:**