

## EXTRACTIONS & WISDOM TEETH REMOVAL WRITTEN INFORMED CONSENT

**Patient:** \_\_\_\_\_

The dentist has explained that I have the following condition: *(Dentist to document in patient's own words)*

\_\_\_\_\_

The following dental treatment will be performed: Removal or extraction of teeth, teeth numbers

\_\_\_\_\_

*(Dentist to document number of teeth to be removed).*

There will be some **pain, swelling and bleeding** following a tooth extraction. This may require pain killers. Bleeding is usually minor and easily controlled by applying pressure.

**RISKS:** There are some risks / complications, which include:

- (a) **Infection** of the extraction socket (**dry socket**). This may cause some pain and discomfort, but is usually easily managed by the dentist.
- (b) **Biting of the numb lip** which may cause damage after the teeth have been removed. Children should be watched closely by your parent/ guardian until the numbness wears off.
- (c) **Damage to the Inferior Dental Nerve** on each side of the Mandible (lower jaw). This nerve passes very close to the root of the lower wisdom tooth (often in contact with it) and gives feeling to the lower teeth, lower lip and chin on that side. This nerve is very close to the area of surgery, with a slight risk of some damage to the nerve. This may cause **numbness** of the lower teeth, lower lip and chin. **This may be temporary (6–12 months) or permanent.**
- (d) **Damage to the Lingual Nerve** on each side of the Mandible (lower jaw). This nerve passes very close to the tongue side of the lower wisdom tooth and posterior mandibular teeth and gives feeling and taste to that side of the tongue. This nerve is very close to the area of surgery, with a slight risk of some damage to the nerve. This may cause numbness and **loss of taste** to that side of the tongue. **This may be temporary (6–12 months) or permanent.**
- (e) **Tooth fracture:** The tooth root tip may break off in small pieces – less than 1-2mm - when the tooth is taken out. The dentist may not remove those pieces if there is a chance that the nerves or other structures may be damaged during removal.
- (f) **Damage to teeth** growing tightly against the wisdom teeth during removal of the wisdom teeth.
- (g) **Weakness of the jaw** due to removal of the wisdom teeth. The **jaw may break** during the procedure or during the healing period.
- (h) If the **upper teeth are close to the sinuses**, removal may cause a hole between the mouth and the sinus. This may need further surgery and specialist oral surgeon referral.

**PATIENT CONSENT: By my signature below, I expressly acknowledge that:**

The dentist has explained my dental condition and the proposed procedure including specialist referral. I understand the risks of the procedure, including the risks that are specific to me, and the likely outcomes. My questions and concerns have been discussed and answered to my satisfaction. I understand that other dental procedures may be done if further dental disease is found during the procedure, or to correct other problems in my mouth.

On the basis of the above statements,

**I REQUEST TO HAVE THE PROCEDURE LISTED HEREIN.**

**Name of Patient :** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*I have explained:* the patient's condition, need for treatment, the procedure and the risks, relevant treatment options and their risks, likely consequences if those risks occur, the significant risks and problems specific to this patient. I have given the patient/ substitute decision-maker an opportunity to ask questions about any of the above matters, raise any other concerns which I have answered as fully as possible. I am of the opinion that the patient/ substitute decision-maker understood the above information.

**Name of Dentist :** \_\_\_\_\_

**Signature :** \_\_\_\_\_

**Date :** \_\_\_\_\_