INFORMED CONSENT FOR EXTRACTION

Our office has recommended tooth removal or extraction as a part of my necessary dental treatment. I understand that surgical removal may be necessary and would involve moving the gum tissue and sectioning the tooth into smaller segments.

I further understand that there may be some unwanted complications, some of which are listed below. No guarantees have been made or implied. Alternative treatments(s) and the option of no treatment have been explained to me. All of my questions have been addressed. I also can read and understand English. Proposed fees have been explained to me, as have any third party insurance benefits. I understand that third party benefits maybe different than discussed by Dr. Cochran as they are not under the control of this office and that I am financially responsible for the proposed dental treatment.

Treatment risks and/or unwanted consequences of the proposed dental treatment may include, but are not limited to:

- Reaction to medications and/or anesthetic
- Temporary or permanent numbness or tingling of the lip, chin, tongue or other areas
- Post treatment bleeding
- Post treatment infection or dry socket
- Post treatment tissue swelling
- Root fragments may break and may be left in the jaw
- Sinus involvement when upper teeth are removed which may require additional treatment or referral to a specialist
- Jaw or alveolar bone may fracture during tooth removal which may require additional treatment or referral to a specialist
- Sensitivity or pain
- Damage to adjacent teeth or restorations

Tooth # being extracted _____ Area: Upper Right Upper Left
Lower Right Lower Left

Patient Signature ____________________ Date _______________

Witness ____________________________

Version May 2006