South River Periodontics

Robert A. Bouffard, D.D.S.
Board Cerified in Periodontics

CONSENT TO DENTAL EXTRACTION

I ______________________________ hereby authorize Dr. R.A. Bouffard DDS to perform the following surgical treatment (s) A description of this treatment has been explained to me, and I understand the risks and complications of both having this procedure and of electing not to have the procedure performed.

Treatment Planned: EXTRACTION OF Tooth/Teeth ____________

Teeth/Areas being treated: _______________________________ I understand that I have a dental condition which has affected the teeth noted to the point where extraction is indicated. This condition and my treatment options have been clearly explained to me and I elect to have Dr. Bouffard perform the necessary procedures to remove this tooth.

The disease process which has damaged my tooth, if left untreated is generally non-reversible, and can be progressive, leading to further damage and potentially, loss of additional teeth and supporting tissues.

I also understand that surgical procedures to extract teeth are invasive by nature and complications may arise. Elevation of a surgical flap and removal of bone and soft tissue may be necessary to extract the tooth. Damage to adjacent nerves may result in temporary or even permanent numbness. Perforation of the maxillary sinus occurs occasionally when upper molar teeth are extracted, and this may necessitate a secondary surgical procedure to close any resultant communication. In some cases it may be determined prudent to terminate extraction procedure and retain root tips and portions of the tooth root, rather than to risk further surgical trauma. Infection of the extraction site and the surrounding tissues may occur, as the extraction procedure is performed in the presence of normal oral flora and pathogenic bacteria. Post-operative bleeding and pain are typically experienced following dental extraction.

While dental extraction therapy is generally successful and without complications, many factors can affect the level of success attained, and therefore, no guarantee, warranty or assurance can be given me that the proposed treatment will be curative and/or successful to my complete satisfaction. A risk of infection, failure, relapse or worsening of my condition may occur. Secondary surgical procedures may be indicated to revise the primary procedure.

Dr. Bouffard and the staff of the Periodontal Department take care to ensure that the potential risk of complications is minimized. It has been explained to me that the long-term success of my treatment requires my cooperation, performance of effective plaque control (home care) on a daily basis, diligent adherence to medication regimen and periodic maintenance visits at this dental office after the proposed surgical treatment is performed. I further understand that if no treatment is rendered, my present dental condition will probably worsen in time, which may result in premature tooth loss. However, it may possibly deteriorate slowly or remain the same without the proposed treatment.

I have been informed that other possible alternative methods of treatment,

My signature affirms that I understand these instructions risks and am willing to abide by the conditions described in this document. I have had the opportunity to ask questions, and have had them answered to my satisfaction.

Signed (Patient): ________________________________ Printed Name: ________________________ Date: _____________

Witness: ____ Printed Name: ________________________ Date: _____________

Doctor: ____ Printed Name: ________________________ Date: _____________

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