FAMILY DENTAL CENTRE
#301, 4015 - 17 Avenue S.E.
Calgary, AB T2A 0S8
PH: 272-1500 FAX: 569-2162

INFORMED CONSENT

Tooth Removal

I understand that the extraction of a tooth (teeth) has been recommended by Dr.__________________ who is a General Dentist. I have had alternative treatment (if any) explained to me, as well as the consequences of doing nothing about my dental conditions. I understand that non-treatment may result in, but not be limited to: infection, swelling, pain, periodontal disease, malocclusion (damage to the way the teeth hit together) and systemic disease.

I understand that there are risks associated with any dental and/or anesthetic procedure. These include but are not limited to:

- Post-operative infection.
- Swelling, bruising, and pain.
- Damage to adjacent teeth or fillings.
- Bleeding requiring more treatment.
- Drug reactions and side effects.
- Possibility of a small fragment of root or bone being left in the jaw when it's removal is not appropriate. Such fragments may work their way partially out of the tissue and need treatment at a later date.
- Damage to sinuses requiring additional treatment or surgical repair at a later date.
- Fracture or dislocation of the jaw.
- Damage to nerves resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas.

I understand the recommended treatment, the fee(s) involved, the risks of treatment, any alternatives and risks of these alternatives, including the consequences of doing nothing. I have had all of my questions answered, and have not been offered any guarantees.

DATE:_____________________________

PATIENT NAME:_____________________________

PATIENT OR GUARDIAN SIGNATURE:_______________________________