

Family Smile Center, LLC
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INFORMED CONSENT FOR ORAL AND MAXILLOFACIAL SURGERY

Procedure: Extraction of Teeth _____

The extraction/extractions of my teeth are being with my approval.

I have been informed of alternative treatments and I understand my teeth can be saved with _____

I understand that if these teeth are not treated or removed my condition may worsen resulting in complications including but not limited to:

1. Infection
2. Loss of additional teeth
3. Pain

Possible complications from the procedure discussed with me include, but are not limited to:

1. Dry socket
2. Infection
3. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and increase risk of complication
4. Bleeding and bruising
5. Swelling
6. Injury to adjacent teeth or fillings
7. Maxillary sinus involvement
8. _____

It is my decision to forgo alternative treatments and have my teeth extracted.

I understand the risks and consequences of this type of treatment.

All of my questions have been answered.

Signature of Patient

Date

Signature of Doctor

Witness