GRAND AVENUE
DENTAL CARE

Dr. Ryan Ross D.D.S
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(406) 245-4922 – (801) 628-3615

Extraction Consent Form

I hereby give permission to Dr. Ryan Ross D.D.S to perform the following procedures and additional procedures as are considered necessary on the basis of findings during said procedure:

Extraction of teeth #'s: _____

Alternative methods of treatment have been discussed such as no treatment at all.
These alternative methods of treatment of are practical and possible, but I desire the treatment mentioned in paragraph 1. The above-named procedures carry certain common inherent risks such as, but not limited to:
A} DRUG REACTIONS AND SIDE EFFECTS
B} POST-OPERATIVE BLEEDING
C} POST OPERATIVE INFECTION OR BONE INFLAMMATION (DRY SOCKET).
D} NECESSARY REMOVAL OF BONE DURING TOOTH EXTRACTION.
E} POSSIBLE INVOLVEMENT OF THE SINUS OF THE UPPER JAW DURING REMOVAL OF UPPER BACK TEETH REQUIRING POSSIBLE SURGERY FOR REPAIR AT A FUTURE DATE.
F} POSSIBLE INVOLVEMENT OF THE NERVE WITHIN THE LOWER JAW DURING REMOVAL OF LOWER MOLAR TEETH, RESULTING IN USUALLY TEMPORARY BUT POSSIBLE PERMANENT NUMBNESS AND /OR TINGLING IN THE LOWER LIP, RIGHT AND/OR LEFT SIDE.

I am aware the practice of dentistry and oral surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of the procedures authorized above.

Patient signature: _____ Date: _____

Witness: _____ Date: _____