



TOOTH EXTRACTION CONSENT

I, _____, consent to Dr. Weiler, and/or his associates performing on me the following extractions:

Teeth #: _____

I hereby acknowledge I have given an accurate report of my past and present physical and mental health history; and, reported **all** major allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I accept and understand the purpose and the nature of the extraction procedure. I also accept and understand what is necessary to accomplish the removal of the tooth/teeth All alternative to this treatment have been **fully explained**.

I accept and understand that if nothing is done, any of the following, but not exclusive of, could occur:
Bone Disease; Bone Loss; Inflammation of Gums; Infection; Sensitivity; Loosening of Teeth Followed by Eventual Tooth Loss; Temporomandibular Joint (Jaw) Problems; Headaches; Referred Pain to The Back of The Neck and Facial Muscles; or, Tired Muscles When Chewing.

The extraction procedure has been **fully explained to me**, including all risks and complication involved. I have been fully informed that the risks and complications (the exact duration of which is undeterminable and potentially irreversible) may include, but are not limited to:

Pain; Swelling; Infection and Discoloration; Numbness of the Lip, Tongue, Cheek, Chin, Teeth; Inflammation of a Vein; Injury to present teeth; Bone Fracture; Sinus Perforation; Delayed Healing; and/or Allergic Reactions to Drugs or Medications Used.

I accept and understand that I elect to have the extraction procedure under local anesthesia, oral sedation; and/or IV sedation when necessary.

I accept and understand there is **NO WARRANTY or GUARANTEE** of any kind as to any result and/or cure.

I accept and understand that there is no method to accurately predict the gum and bone healing capabilities following extractions.

I accept and understand that **excessive smoking, alcohol use, or sugar consumption** may affect gum healing and may result in complications related to healing. I agree to follow all homecare instructions and present for all examinations as instructed.

If I suffer from injury of any kind as an actual and proximate result of my not following homecare instructions, I hereby absolve Dr. Joshua Weiler and/or his associates of all financial and/or legal liability.

I have had the opportunity to discuss the extraction procedure and have had an opportunity to ask questions, and I am fully satisfied with the answers received.

If, during the extraction procedure. A change in treatment is required to fully the complete treatment plan, I authorize the doctor and the operative team to make whatever changes they deem in their professional judgement is necessary. I understand that I have the right to designate the individual who will make such a decision.

Patient's Signature (or Parent/Guardian): _____ Date: _____

Patient's Name (or Parent/Guardian): _____ Date: _____

Witness' Name: & Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Please contact Dr. Weiler with any further questions or concerns:

drweiler@thehamptonsdentist.com | office: (631) 998-3980 | cell: (516) 316-4624