Mark Sebastian, DMD
Practice limited to periodontics and dental implants
33516 Ninth Ave. South, #2
Federal Way, WA 98003
(253) 941-6242 --or -- (253) 952-2005
(253) 952-2129 FAX
fwperio@aol.com

Consent for extraction(s)

Recommended Treatment: Dr. Sebastian has recommended that a tooth or several teeth be extracted (pulled). Local anesthetic (commonly called novocain) will be administered as part of doing the extraction.

Principal Risks and Complications Complications that may result from surgery could involve the surgery procedure, bone regenerative materials, drugs, or anesthetics. These complications include, but are not limited to post-surgical infection, bleeding, swelling, pain, facial bruising, jaw joint pain or muscle spasm, cracking or bruising of the corners of the mouth, restricted ability to open the mouth for several days or weeks, impact on speech, allergic reactions, accidental swallowing of foreign matter, and transient (on rarest of occasions permanent) increased tooth looseness, tooth sensitivity to hot, cold, sweet or acidic foods, and transient (on rare occasions permanent) numbness of the jaw, lip, tongue, chin or gums. A dry socket can cause pain for about a week. *Extracted teeth that are not replaced may lead to the other teeth moving or drifting, creating spaces between the remaining teeth and making it difficult to impossible to replace them or straighten them later*. The exact duration of any complication cannot be determined, and they may be irreversible.

Alternatives to suggested Treatment: No extraction(s).

Necessary Follow-up Care and Self-Care: It is important for me to continue to see my regular dentist for routine dental care and to get the missing tooth/teeth replaced as recommended.

Smoking may adversely affect extraction site healing and may cause a dry socket (very painful for about a week). Smokers have more dry sockets than non-smokers.

I should not use a water-pik for 2 weeks as it can cause a dry socket.

I have told Dr. Sebastian about any pertinent medical conditions I have, allergies (especially to medications or sulfites (many local anesthetics have sulfite preservatives))

Initials_____

or medications I am taking, including over the counter medications such as aspirin.

I need to come back in for several post-operative check-ups so that healing may be monitored and so Dr. Sebastian can evaluate and report on the outcome of surgery to my dentist.

I know that it is important to:

1. Abide by the specific prescriptions and instructions given.
2. See Dr Sebastian for post-operative check-ups as needed.
3. Not smoke or use smokeless tobacco for 2 weeks.
4. Avoid water-piks as mentioned above until the site is healed.
5. Have any non-dissolvable sutures (stitches) removed.
6. Get the tooth/teeth replaced as recommended.

No Warranty or Guarantee: While in most cases tooth extraction heals quickly and with out any problems, complications such as those listed previously, can happen despite the best of care.

Publication of Records: I authorize photos, slides, x-rays or any other viewing of my care and treatment during or after its completion to be used for either the advancement of dentistry or in promotional materials. My identity will not be revealed to the general public.

Communication with my insurance company, my dentist or other dental/medical providers: I authorize sending correspondence, reports, chart notes, photos, x-rays and other information pertaining to my treatment before, during or after its completion with my insurance carriers, my dentist, and any other health care provider I may have who may have a need to know about my dental treatment.

Females Only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

Procedure(s) to be performed:

_____

_____

_____

_____

Initials_____

Consent to have tooth extraction(s)

I have been informed of the nature of my dental problem, the procedure to be utilized, the risks and benefits of having this extraction oral surgery, the alternative treatments available, the necessity for follow-up and self-care, and the necessity of telling Dr. Sebastian of any pertinent medical conditions and prescription and non-prescription medications I am taking. I have had an opportunity to ask questions. I consent to the performance of the extraction oral surgery as presented to me during my consultation and as described in this document above. I also consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Sebastian. I have read and understand this document before I signed it.

_____ _____

Date [Printed name of patient, parent or guardian]

_____

[Signature of patient, parent or guardian]

_____ _____

Date [Printed name of witness]

_____

[Signature of witness]