



# IMPRESSIONS DENTAL

5970 S. COOPER RD. STE #1 CHANDLER, AZ 85249 • (480) 814-8888

## Dental Treatment Consent Form Extractions

I authorize my dentist to remove the following teeth\_\_\_\_\_. If it is an option, I understand that alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.). I understand removing teeth does not always remove infection, if present, and it may be necessary to have further treatment. I understand that in most cases analgesics are required to numb the area being worked on; analgesics can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue or surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Patient Name: \_\_\_\_\_

Patient and/or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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