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Informed Consent for Extraction

I, _____, hereby authorize and request that Dr. Barbagallo perform the following extractions for my child _____.

I understand that tooth/teeth _____ are baby / permanent.
I am aware that an extraction involves the removal of tooth structure and the root system of that tooth.

I am aware that there are possible risks and complications that could occur which include but are not limited to the following:

- pain, bleeding and swelling
- discoloration and bruising
- infection (requiring additional procedures)
- dry socket, inadequate clot formation, prolonged healing requiring medicated packing.
- allergic reaction and/or rashes
- nausea and vomiting
- fractured root tip and/or fractured root, formation of bony splinters
- residual root/tooth structure being left behind requiring another procedure.

Alternatives: Alternatives to removal have been explained to me.

- No treatment
- Pulpotomy & SSC Crown
- Extraction and possibly space maintenance

Loss of feeling in the teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or in a rare case may be permanent, or fractured jaw.

I am aware that the dentist does not guarantee the success of the treatment that will be performed and that there are known and accepted complications from dental procedures that can occur even when the dentist has acted reasonably and properly. I hereby authorize the treatment knowing these potential risks.

I hereby acknowledge that by reading this form, and in discussion with the doctor, I understand the risks involved with extraction as well as the purpose for this treatment.

Date: _____

Signed:_____ Witness:_____