

PATIENT: _____
DATE: _____

EXTRACTION INFORMED CONSENT

I have been informed I require the following teeth extracted:

UPPER RIGHT	8 7 6 5 4 3 2 1		1 2 3 4 5 6 7 8	UPPER LEFT
LOWER RIGHT	8 7 6 5 4 3 2 1		1 2 3 4 5 6 7 8	LOWER LEFT

The surgical procedure may last from thirty to sixty (30-60) minutes. The wound will be closed with dissolving stitches. Home care instructions and required prescriptions will be provided after the surgery. I will be seen in the office in one week to check the surgical site, and to be shown how to care for the site. It may take five to seven (5-7) days for my mouth to feel comfortable, and another two to four (2-4) weeks for the tissue around the site to heal completely. If I have been prescribed a sedative, I will be drowsy following surgery and have arranged to have a responsible adult available to take me home.

I have had the purpose, benefits, reasonable risks and alternatives, if any, to the procedure(s) explained to me. I have carefully read and understood all available explanatory material and have been given copies. I have been given the opportunity to ask questions.

I hereby authorize Dr. Bruno Paliani to perform the aforementioned procedure(s) necessary to my dental treatment, and any additional treatment procedures as are considered immediately necessary on the basis of findings during the above mentioned treatment.

Gums or tissues involved in the anaesthetic injection may be sore for several days following treatment. Swelling of the tissues around the injection site is possible and can be treated by applying pressure and cold (ie. ice packs) the day of treatment to the area of swelling for a minimum of 1-2 minutes. In addition, if freezing involves the lower jaws, there may be difficulty opening the jaw for the first few days. The soreness and stiffness will dissipate with time but warm salt water rinses or moist heat on the side of treatment will facilitate healing. Transient facial paralysis is a rare possibility upon anaesthetic injection, but it will almost always resolve itself without any future consequences.

I consent to the administration of such local anaesthesia and/or medication as is required for the aforementioned dental treatment. It is understood that I am unable to take the following medication:

I understand that medications, drugs, and anaesthetics may cause drowsiness, incoordination, and an unawareness that may be compounded by the use of alcohol or other drugs. I have been advised, understand, and agree not to operate any vehicle, hazardous device, or machinery for at least twenty four (24) hours, or until fully recovered from the effects of the anaesthetic and/or medication that may have been administered or prescribed.

I consent to the taking of photographs throughout the entire treatment procedure. Should these

photographs be deemed by Dr. Bruno Paliani to benefit dental research, science, or education, I consent to their publication and republication, either separately or together, in professional journals or dental books or used for any other purpose which Dr. Bruno Paliani may deem proper in the interest of dental education, knowledge or research.

The dental fees of the procedure have been outlined clearly and I agree to comply with the office's payment policy.

PROFESSIONAL FEE _____

LAB FEE (approx.) _____

TOTAL FEE (approx.) _____

Dated at London, Ontario, this _____ day of _____

SIGNED: _____
PATIENT

WITNESS: SIGNED: _____
Parent, Guardian or Nearest Kin if patient
is under the age of 18