

Art of Periodontics
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**Consent
For
Tooth Extraction**

You have been given pertinent information about your proposed tooth/teeth extraction so that you have sufficient information to make the decision as to whether or not to proceed with surgery. What you are being asked to sign is a conformation that we have discussed the nature of the proposed treatment, the known risks associated with it and the feasible alternate treatments.

Please initial each paragraph after reading. If you have, any questions please ask your doctor before initializing.

Patient: _____ Date: _____

1. I hereby authorize Dr. MahnazZandi and any other staff, assistants or employees selected by to treat the condition described as tooth/teeth extraction. It has been explained to me that I need extraction (s) of the following tooth/teeth. _____

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

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2. I understand that this procedure is being performed due to a poor prognosis of the tooth/teeth condition. Different options for tooth/teeth replacement has been explained to me. _____
3. I understand incisions will be made inside my mouth that will allow for access to remove tooth/teeth and their roots. I acknowledge that the doctor has explained the procedure, including the location of the incisions. _____
4. No guarantee can be or has been given that the bone will consolidate and thus be adequate for future implant placement. Additional bone and/or gum augmentation procedures may be necessary to gain sufficient tissue for implant, bridge, or denture placement. _____
5. Dr. MahnazZandi has explained to me that there are certain inherent and potential risks and side effects in any surgical procedure and in this specific instance, such risks include, but are not limited to the following:
- A. Postoperative discomfort and swelling that may require several days of at home recuperation. _____
 - B. Prolonged or heavy bleeding that may require additional treatment. _____
 - C. Injury or damage to adjacent teeth or roots of adjacent teeth if present. _____
 - D. Postoperative infection that may require additional treatment including removal of graft. _____
 - E. Stretching of the corners of the mouth that may cause cracking and bruising, may heal slowly. _____
 - F. Restricted mouth opening for several days, sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ). Pre-existing TMJ symptoms may be worsened. _____
 - G. Injury to the nerve branches in the jaw resulting in numbness or tingling of the chin, lips, check gums, teeth, lower eyelid, side of the nose, or the tongue on the operated side. This may persist for several weeks, months or in rare instances, permanently. _____
 - H. Some bleeding through the nostril on the side of surgery may occur which usually will last on to two days. _____
 - I. I understand that if I am a smoker, I should not smoke one day prior to surgery, the day of surgery and one following surgery. _____
 - J. Swelling around the eye of the surgical side may even result in closing of the eye for a day or two. _____
 - K. Opening into the sinus after surgery can occur and require additional treatment. _____
 - L. Infection of the extraction site or the graft, possibly necessitating its total removal. The removal of grafted bone has its owned potential risks and complication, which also have been explained to me. _____

6. It has been explained to me that during the course of this procedure, unforeseen condition may be revealed which will necessitate extension of the original procedure or a different from those set forth in Paragraph 2 above. In rare cases, it may not be possible to continue with the procedure. I authorize my doctor and his staff to perform such different procedure (s) as necessary and desirable in the exercise of professional judgment. _____
7. I consent to the administration of local anesthesia in connection with the procedure referred to above. On occasions, local anesthesia administration may cause soreness, muscle spasm and limited jaw opening for several days or weeks due to intramuscular injection. If intravenous anesthesia is used, there may be soreness at the injection site or along the vein, as well as some bruising around the injection site. In rare cases, the vein irritation may cause restricted mobility of the arm or hand and may require additional treatment. _____
8. I have been made aware that certain medications, drugs anesthetics and prescription which I may be given can cause drowsiness, incoordination, and lack of awareness which as may be increased by the use of alcohol and other drugs. I have been advised not to operate any vehicle or hazardous machinery and not to return to work while taking such medications, or until fully recovered from the effects of the same. I understand this recovery may take up to 24 hours or more after I have taken the last dose of medication. If I am to be given sedative medication during my surgery, I agree not to drive myself home and will have a responsible adult drive me home and accompany me until I am fully recovered from the effects of the sedation. _____
9. If intravenous anesthesia is used, I understand that I am not to have **anything or have not had anything** by for at least six hours before my surgery. _____
10. It has been explained to me, and I understand, that a perfect result is not, and cannot be guaranteed or warranted. _____
11. I certify that I speak, read, and write English and have read and fully understand this consent for surgery; and that all blanks were filled in prior to my initialing and signing this form. _____
12. I authorize photos, slides, x-rays or any other viewing of my care treatment during or after its completion to be used for the advancement of dentistry and for any reimbursement purposes. However, my identity will not be revealed to the general public without permission. _____

Please ask the doctor if you have any questions concerning this consent form.

Patient's or legal guardian's signature

Date

Witness signature

Date