Extraction Consent

Date:___________________

I _______________________________________hereby authorize Dr. Randolph Resnik
To perform the following procedures:____
____
____
____

I am also aware that the procedure will involve the use of local anesthetic and/or intravenous sedation. I realize that there are risks involved in this operation and in the anesthesia or sedation process. Some of the complications and risks include but are not limited to:

1. Bleeding and swelling
2. Postoperative infections
3. Trismus (inability to open mouth wide)
4. Postoperative nausea and vomiting
5. Injury to adjacent teeth and fillings
6. Decision to leave small root in jaw when removal would be detrimental
7. Opening of the sinus when removing upper teeth
8. Thrombophlebitis
9. Jaw fracture
10. Numbness in lower lip, chin or tongue following the removal of lower teeth
11. Cardiac arrest
12. Temporomandibular joint soreness
13. Other ____

I further understand that this is an elective procedure and other forms of treatment or no treatment at all are choices that I have. I am satisfied with the explanation of the operation, risks, and/or possible alternative treatment. I specifically consent to the procedure outlined above and I authorize the above mentioned doctor to perform such other procedures as may be necessary in his judgment if such need arises in the course of this treatment. Also, no guarantee has been made as to the procedure outlined above.

____ ________________
Signature of Patient Date

____ ________________
Signature of Witness Date

____ ________________
Signature of Doctor Date