INFORMED CONSENT

FOR

TOOTH EXTRACTION

Extraction of tooth/teeth name(s)/number(s):_____________________________________

I, __________________________________________, authorize George H. Maxfield, D.M.D.,

to remove the tooth/teeth listed above because: (1) the tooth either has a hopeless prognosis and
cannot be saved with a root canal and/or gum treatment procedure; or (2) is causing the
deterioration of other teeth; or (3) is interfering with dental restorative procedures or orthodontic
tooth straightening; or (4) is causing me pain and/or infection and I DO NOT want or cannot
afford to have a root canal and/or gum treatment procedure to help save the tooth. I have also
been given an opportunity to see an oral surgeon to be sedated (“put out”) but elect to have the
treatment in this office under (“novocaine”) local anaesthesia only.

The procedure may involve incision into the gums to gain access to the involved teeth and to
facilitate removal. It may also involve cutting tooth and bone tissue in order to insure that all parts
of the tooth and roots are removed. Sutures (“stitches”) may be placed.

Common complications of tooth extraction can be pain, swelling, bruising of the face (“black and
blue”), or jaw muscle spasm/limited opening (“trismus”). Other, uncommon, complications can
occur. These include, but are not limited to: (1) infection; (2) bleeding; (3) tooth roots or remnants
that cannot be retrieved from inside the jaw; (4) damage/breakage/removal of adjacent teeth and/or
restorations, i.e. adjacent teeth, fillings and/or crowns can become dislodged or break; (5) painful,
delayed healing ("dry socket"); (6) permanent opening/perforation into the sinuses of the upper jaw;
(7) embedding of teeth or dental restorations into these sinuses; (8) temporary or permanent
damage (manifested by “numbness”) to the nerves of the tongue and/or lip; (9) swallowing into the
stomach/intestinal tract or aspirating (“sucking into”) into the “windpipe”/lungs of tooth,
fragments, or dental restorations or other foreign objects; and a (10) fractured (“broken”) jaw.

I understand that, AT MY OWN EXPENSE, further surgical dental/medical procedures or new
fillings/crowns/bridges, either in this office or by referral to another dental/medical practitioner,
might be needed to correct these complications.

All of my questions have been answered regarding this proposed treatment.

X______________________________________________________________

Patient or Parent/Guardian

Date