Greenwoods™ Dental & Surgical Centres

★ **693 McPhillips Street, Winnipeg, Manitoba R2X 2H6** **(204) 774-7774** **Fax (204) 633-1143**

249½ Henderson Highway, Winnipeg, Manitoba R2L 1M3 (204) 775-7775 Fax (204) 667-6229

246 Portage Avenue, Winnipeg, Manitoba R3C 0B1 (204) 779-7779 Fax (204) 594-5768

1531 Pembina Highway, Winnipeg, Manitoba R3T 2E5 (204) 221-2221 Fax (204) 504-5111

1462 Regent Avenue West, Winnipeg, Manitoba R2C 3A8 COMING SOON

1128 Richards Street, Vancouver, BC V6B 3E6 (604) 566-7666 Fax (604) 566-7660

First Name _____ Last Name _____ Date of Birth _____

It has been recommended that I have the following tooth (teeth) extracted by Dr. _____:

The extraction is necessary because of:

☐ **Pain** ☐ **Infection** ☐ **Periodontal (gum) disease**

☐ **Decay** ☐ **Broken tooth / teeth** ☐ **Non-restorable tooth / teeth**

☐ **Other** _____

RISKS OF EXTRACTION

I have been informed and fully understand that there are certain inherent and potential risks associated with any type of surgical procedure, including extractions. I understand that during and following treatment, I may experience pain or discomfort, bleeding, swelling, bruising, and stiff jaws, all of which may last for several days. I understand that it is possible for an infection to occur in the extraction site and that I may need antibiotics and/or other procedures to treat the infection.

I understand that less common complications include: dry socket (lost blood clot); loss or loosening of dental restorations; loss or injury to adjacent teeth and soft tissues; jaw fractures; sinus exposure (upper teeth); swallowing or aspiration of teeth and restorations. I understand that small root fragments may break off from the tooth being extracted. Depending on their size and position, they may either be left to remain in the jaw or may require additional surgery for removal.

I understand that during surgery it may be impossible to avoid touching, moving, stretching, or injuring the nerves in my jaw that control sensations and function in my lips, tongue, chin, teeth, and mouth. This may result in nerve disturbances such as temporary or permanent numbness, itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

ACKNOWLEDGMENT

I will follow any and all treatment and post-treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including X-rays.

I have discussed my treatment with my dentist and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, the risks of refusing treatment, and I acknowledge that no guarantees, warranties, or representations have been made to me concerning the results of the treatment.

I understand the risks and elect to have this procedure performed by Dr._____. I understand that if any unexpected difficulties occur during treatment, I may be referred to an oral surgeon for further care.

_____ _____

PATIENT / GUARDIAN SIGNATURE DATE

_____ _____

TREATING DENTIST DATE