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MAXILLOFACIAL SURGERY | PERIODONTICS
IMPLANT DENTISTRY | SLEEP APNEA & TMD

Informed Consent for Coronectomies

Diagnosis: _____

Purpose of Extraction: I have been informed that the purpose of removing my tooth/teeth is _____

Alternative Treatment: The following reasonable alternatives to extractions have been explained to me:

- Retaining tooth/teeth as is and monitoring with your dentist longterm.
- Leaving a portion of the tooth roots or teeth (coronectomy) to try and decrease risk of damage to adjacent structures (sinus or nerve).

Surgical Procedures may involve some, or all, of the following:

- Use of local anesthetic, oral or intravenous sedation, antibiotics, analgesics and sutures (stitches).
- Use of a bone graft to preserve the bone on neighboring teeth or to fill deficits. The bone may be my own bone, human donor bone or cow bone and a membrane (which may require an additional procedure to remove the membrane) may be utilized.

Risks and Complications of extraction and bone graft (if applicable): I understand that the risks and complications include, but are not limited to:

- Allergic reactions to dental materials/medications,
- Bleeding, swelling, infection,
- Pain and/or tooth sensitivity,
- Bruising,
- Perforation of upper jaw sinus or nasal cavity,
- Bone fracture,
- Scarring,
- Damage to other teeth/roots – which may need repair or removal,
- Damage to dental appliances,
- Cracking/stretching corners of mouth,
- Cuts inside mouth or on lips,
- Slow healing,
- Temporary restriction of mouth opening,
- Stress or damage to jaw joints (TMJ),
- Increased tooth/teeth mobility of neighboring teeth,
- Possible altered or loss of sensation due to dental nerve damage (teeth, gums, lips, tongue, cheeks, face, palate, chin) including loss of taste which may resolve or time, but in some cases may be permanent,
- Dry socket,
- Bony ridges or splinters that may require further treatment,
- Part of tooth and/or roots may be left to prevent damage to nerves or other structures,
- Nerve injury in the place the graft was taken from or where it is placed if applicable,
- Rare chance of disease spread from processed bone,
- Failure/infection of the bone graft.

Risks and Complications of local anesthetic use: I understand that the risks and complications associated with the use of local anesthetic include, but are not limited to: Nerve injury, which may occur from the delivery of local anaesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve, but in some cases may be permanent.

No Warranty or Guarantee: I understand that the doctor cannot guarantee the results of the procedure.

Consent to Unforeseen Conditions: During treatment, unknown conditions, such as discovery of changed prognosis for adjacent structures or teeth, may modify or change the original treatment plan. I therefore authorize the treating dentist to do additional or alternative procedures if, in his/her professional judgment, it is in my best interest.

Compliance with Self-Care Instructions:
In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I understand that excessive smoking and/or alcohol intake may affect healing and may limit the successful outcome of my surgery.

I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice good oral hygiene, keep all appointments, make return appointments if complications arise and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.

Supplemental Records and Their Use: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of any and all procedures related to extraction and bone grafting as presented to me during the consultation and treatment plan presentation by the dentist.

_____ _____ _____
Signature of Responsible Party Date Patient's Name

_____
Relationship to Party (if Responsible Party is not Patient)

I confirm with my signature that I have discussed with the above-named patient the risks, potential complications, and intended benefits of the dental implants, as well as alternatives. The patient has had the opportunity to ask questions, all questions have been answered, and the patient has expressed understanding. Thus informed, the patient has requested that I extract the aforementioned tooth/teeth and bone graft (if applicable) him/her.

_____ _____
Signature of Dentist Date

_____ _____
Witness to Signatures Only Date