Michael C. Stypula, D.D.S., M.D.S.

INFORMED CONSENT FOR EXTRACTION

This disclosure is an effort to make you better informed so that you may give or withhold your consent to the proposed procedure.

This is my consent for Dr. Stypula to perform the indicated necessary and recommended treatment procedure/surgery: _____as previously explained to me, or other procedures deemed necessary or advisable and necessary to complete the planned operation.

I understand the purpose of the procedure/surgery is to surgically remove a tooth (or teeth) that either cannot be saved by treatment; I choose extraction in lieu of recommended treatment; or impaction necessitates the removal. The doctor has advised me that if this condition persists without treatment or extraction, my present oral condition will probably worsen in time, and the risk to my health may include; but are not limited to the following: swelling; pain; infection; cyst formation; periodontal (gum) disease; and/or premature loss of bone. I also understand that there is no guarantee that the outcome of the extraction will meet the usual expectations of success.

It has been explained to me that there are certain inherent and potential risks in the treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to: postoperative discomfort and swelling that may require additional treatment and prolonged recuperation; heavy bleeding that may be prolonged; injury to adjacent teeth and fillings; postoperative infection requiring additional treatment; stretching of the corners of the mouth with resulting cracking and bruising; restricted mouth opening for several days or weeks; injury to the nerve underlying the teeth resulting in numbness of tingling to the lip, chin, gums, cheek, teeth, and/or tongue- this may persist for several weeks, months, or in rare instances be permanent; opening of the maxillary sinus (a normal cavity situated above the upper teeth) requiring additional surgery; and , intraoral and/or extraoral discoloration (bruising) of the skin/tissues at the site of surgery.

I consent to administration of such local anesthesia as deemed necessary by the doctor to accomplish the proposed procedure. If the doctor feels it necessary, I consent to the taking of a biopsy, sending it to an outside lab for analysis, and being responsible for paying the lab for its services (the lab fee is separate from Dr. Stypula's charges).

If any unforeseen condition should arise in the course of the operation calling for the doctor's judgment, or for procedures in addition to, or different from those now contemplated, I request an authorized doctor to do whatever he/she may deem advisable in attempting to gain a favorable prognosis.

I have had an opportunity to discuss with the doctor the procedure, my past medical/dental history including any serious problems, injuries, and any allergies, to my satisfaction.

Medications, drugs, anesthetics, and prescriptions may cause drowsiness, and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to operate any vehicle, automobile, or hazardous devices, while taking such medications and/or drugs, until fully recovered from the effects of same.

I agree to cooperate completely with the recommendations of the doctor while I am under treatment (e.g. postoperative instructions, dental home care and recall appointments), realizing that any lack of same could result in a less than optimal result.

I certify that I have had an opportunity to read and fully understand the terms and words within the above consent and the explanations made to me by the doctor. I believe I have been given and understand sufficient information to my consent to the above extraction.

_____	_____
Patient's (Parent's) Full Name	Witness' Full Name
_____	_____
Patient's (Parent's) Signature	Witness' Signature
_____	_____
Date	Date