



Consent for Oral Extractions

I hereby authorize Leesburg Dental to perform the following procedure(s) upon me:

I have elected to have the above surgical procedure(s) performed under Local anesthesia only.

I understand that there are certain risks associated with oral extractions, including but not limited to the following:

- Post-operative discomfort and swelling
- Bleeding which may be heavy or prolonged
- Injury to adjacent teeth and fillings
- Post-operative infection which may require additional treatment
- Stretching of the corners of the mouth that may cause cracking and bruising
- Restricted mouth opening for several days sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ)
- Decision to leave a small piece of root in the jaw when its removal would require extensive surgery or treatment
- Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, cheek, gums, tongue or teeth
- Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery

I understand that no guarantees can be made and I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed surgery and anesthesia. I certify that I speak, read and write English.

Patient (or legal guardian) signature

Date

Doctor's signature

Date

Witness's signature

Date