STORY CITY DENTAL

INFORMED CONSENT FOR WISDOM TOOTH REMOVAL

I understand that oral surgery and or dental extractions regardless of where they are completed include possible inherent risks. These risks include but are not limited to:

1. **INJURY TO ADJACENT TEETH, FILLINGS, OR CROWNS** may occur no matter how carefully surgical procedures are performed. Fractured fillings or crowns may require replacement.
2. **MUSCLE OR JAW SORENESS** may be noticed following oral surgery and especially wisdom tooth extractions. Anyone with preexisting TMJ issues can see an aggravation of these following wisdom tooth removal. Symptoms of this can include clicking, popping of the TMJ muscle, soreness on opening, and limited range of motion of the jaw following surgery. If these symptoms do no resolve, patients are encouraged to call our office. Patients must notify us of any such preexisting conditions prior to surgery.
3. **UNUSUAL REACTIONS TO MEDICATIONS** given or prescribed. Reactions of a mild or severe nature may possibly occur from anesthetics or medications administered or prescribed. It is important to take all prescribed medications according to the instructions.
4. **DRY SOCKET** occurs when the blood clot that forms in the extraction socket of a removed tooth is dislodged and another clot does not form in its place. These tend to be extremely painful. Drinking liquids through a straw, smoking and simply not following the post-op instructions increase the likelihood of this happening.
5. **INFECTION:** No matter how carefully surgical sterility is maintained, the oral cavity is not a sterile place, and on rare occasion bacteria from your mouth can cause a post op infection. If severe swelling occurs, that is accompanied by a fever and malaise, immediately contact us. Untreated post op infections can result in hospitalization and possibly the use of IV antibiotics.
6. **BLEEDING AND BRUISING** can last for hours after surgery. Should it persist and increase in severity, please contact us immediately. Bruising may be prolonged, but tends to be restricted to the cheeks.
7. **SINUS PERFORATION:** in some cases, the root tips of an upper tooth lie close to the sinuses. During extraction, the thin bone that separates the oral cavity from the sinuses can be perforated. Should this occur, closure upon healing is usually seen. In rare cases the sinus may need to repaired in a second appointment.
8. **FRACTURED JAW OR TOOTH ROOTS:** There is a possibility, even though extreme care is exercised, that the jawbone, may be fractured requiring a referral to a specialist for treatment. A decision may be made to leave a small piece of root of bone fragment in the jaw as its removal would require extensive surgery or substantially increase the risk of complication during surgery.
9. **INJURY TO THE NERVES OF THE LIPS, TONGUE, THE TISSUES IN THE FLOOR OF THE MOUTH AND CHEEKS, ETC.** These possible nerve injuries can cause numbness, tingling, burning and loss of taste with respect to the tongue. These alterations of sensation usually are temporary lasting a few days to a few months, however, in rare cases it can be permanent.
10. **IT IS MY RESPONSIBILITY TO CONTACT THE DENTIST AND SEEK ATTENTION SHOULD ANY UNDUE CIRCUMSTANCES OCCUR POST OPERATIVELY AND I SHALL DILIGENTLY FOLLOW ANY PREOPERATIVE AND POST-OPERATIVE INSTRUCTIONS GIVEN TO ME.**
11. **I UNDERSTAND THAT DR. BINKOWSKI IS A LICENSED GENERAL DENTIST WITH RESIDENCY-BASED SURGICAL AND IV SEDATION TRAINING** as well as nearly 10 years of experience at removing wisdom teeth. I understand that he is not an oral and maxillofacial surgeon and I choose not to be referred to an oral and maxillofacial surgeon for this procedure.

INFORMED CONSENT

I have been given the opportunity to ask any and all questions regarding the nature and purpose of surgical treatment and/or extraction of teeth and have received answers to my satisfaction. I have been given the option of seeking care with an oral and maxillofacial surgeon and voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of the treatment to be rendered to me. By signing this form, I am freely giving my consent to allow and authorize Dr. Binkowski to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient Name (printed)	Signature of patient, legal guardian or power of attorney	Date

Staff Witness (printed)	Signature of Witness	Date