# Informed Consent Form for Dental Extraction

This **informed consent form** for dental extraction ensures that you, the patient, fully understand the proposed procedure and its associated risks and benefits prior to consenting to treatment. Please carefully review the information below and feel free to ask any questions before signing this document.

## Patient Information

Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____

## Procedure Description

I understand that my treating dentist has recommended the extraction (removal) of the following tooth/teeth:
_____

## Risks and Possible Complications

- Pain, swelling, bruising, and bleeding
- Infection at the extraction site
- Delayed healing or dry socket
- Injury to adjacent teeth, gums, or restorations
- Numbness, tingling, or altered sensation of the lips, tongue, chin (rare)
- Sinus complications (for upper teeth)
- Jaw joint discomfort or stiffness

## Benefits

- Relief of infection or pain
- Preventing spread of disease to other teeth
- Improved oral health

## Alternative Treatments

Possible alternatives to dental extraction may include, but are not limited to:

- Root canal therapy
- Restorative procedures (fillings, crowns)
- Monitoring without immediate treatment

## Patient Acknowledgment and Consent

I have read and understood the information provided above regarding the dental extraction procedure. My questions have been answered, and I am aware of the risks, benefits, and alternatives. By signing below, I give my informed consent for the dental extraction to be performed by my dentist and their team.

Patient/Guardian Signature: _____ Date: _____
Dentist Signature: _____ Date: _____

*This document promotes transparency and protects both the patient and dental provider. It is essential for ethical and legal compliance in dental care.*