Clifton E. Nakatani DDS MSD
Practice Limited to Periodontics and Implants

CONSENT FOR EXTRACTION

FACTS FOR CONSIDERATION: An extraction involves removing one or more teeth. Depending on the condition, this may require sectioning the teeth or trimming the gum or bone tissue. If any unexpected difficulties occur during treatment, I may be referred to an oral surgeon.

Once the tooth/teeth is/are extracted, I will have a space that I may want to fill with a fixed or removable appliance. Replacement of the missing tooth/teeth may be necessary to prevent the drifting of adjacent and/or opposing teeth to maintain function, or for cosmetic appearances. The option of a fixed or removable appliance was explained to me.

As in all surgical procedures, extractions may not be perfectly safe. Since each person is unique and responds differently to surgery, the healing process may vary; no guarantees can be made.

BENEFITS OF EXTRACTION, NOT LIMITED TO THE FOLLOWING: The proposed treatment should help to relieve symptoms and may also enable me to proceed with further proposed treatment.

RISKS RELATED TO THE SUGGESTED TREATMENT, NOT LIMITED TO THE FOLLOWING: I understand that following treatment I may experience bleeding, pain, swelling, and discomfort for several days, which may be treated with pain medication. It is possible infection can follow an extraction and must be treated with antibiotics or other procedures. I will contact the office immediately if symptoms persist or worsen. I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and make it difficult for me to open for several days. However, this can occasionally be an indication of a further problem. I must notify the office if this or other concerns arise. I understand that the necessary blood clot that forms in the socket may disintegrate or dislodge. This painful condition, called dry socket, lasts approximately a week or more and is treated by placing a medicated dressing in the tooth socket to aid healing. To protect against developing dry socket I must NOT smoke, drink through a straw, chew food in that area, or disturb the socket in any way for 24 to 48 hours. I understand that the instruments used in extracting a tooth may unavoidably chip or damage adjacent teeth, which could require further treatment to restore their appearance or function. I understand that upper teeth have roots that may extend close to the sinuses. Removing these teeth may temporarily leave a small opening into the sinuses. Antibiotics and additional treatment may be needed to prevent a sinus infection and help this opening close. I understand that an extraction may cause a fracture in the surrounding bone. Occasionally, the tooth to be extracted may be fused to the surrounding bone. In both situations, additional treatment is necessary. Bone fragments called "spicules" may arise at the site following extraction and are generally easily removed. I understand that tooth fragments may be left in the extraction site(s) following treatment due to the condition and position of the tooth/teeth. Generally, this causes no problems, but on rare occasions the fragments become infected and must be removed. I understand that the nerves that control sensations in my teeth, gums, tongue, lips, and chin run through my jaw. Depending on the tooth to be extracted (particularly lower teeth or third molars), occasionally it may be impossible to avoid touching, moving, stretching, bruising, cutting, or severing a nerve. This could change the normal sensations in any of these areas, causing itching, tingling or burning, or the loss of all sensations. These changes could last from several weeks to several months, or in some cases, indefinitely.

CONSEQUENCES IF NO TREATMENT IS ADMINISTERED, NOT LIMITED TO THE FOLLOWING: I understand that if no treatment is performed, I may continue to experience symptoms, which could include pain and/or infection, deterioration of the bone surrounding my teeth, changes to my bite, discomfort in my jaw joint, and possibly the premature loss of other teeth.

ALTERNATIVE TREATMENTS IF EXTRACTION IS NOT THE ONLY SOLUTION, NOT LIMITED TO THE FOLLOWING: I understand that depending on my diagnosis, alternatives to extraction may exist which involve other discipline in dentistry. I asked Dr. Nakatani about them and their respective costs. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits, and costs.

CONSENT TO UNFORSEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. These may include, but not limited to, extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root of a multi-rooted tooth so as to preserve the tooth, the placement of a bone graft material or the material to guide (enhance) tissue regeneration or termination of the procedure prior to completion of all of the surgery originally outlined. I, therefore, consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of Dr. Nakatani.

INITIAL X

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BLOOD CONCENTRATES: I give my consent to use my own blood in the surgical procedure utilizing my blood concentrate. The amount of blood drawn for this procedure is approximately 20-66 cc's.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording, and x-rays of my oral structures as related to the procedure. I give consent that my records may be used for educational use in lectures or publications provided that my identity is NOT revealed.

ANESTHESIA

☒ Local anesthesia will be used.

☐ Local anesthesia with oral anti-anxiety medication. **If you take this medication, YOU CANNOT DRIVE. You will need a driver to stay in our office for the duration of the surgical visit.**

ANESTHESIA RISKS include discomfort, swelling, bruising, infection, prolonged numbness, and/or an allergic reaction.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I agree to diligently comply with any and all pre-operative and post-operative instructions given to me. I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of my treatment. It is my responsibility to timely seek attention should any undue circumstances occur post-operatively. I agree to report for post-operative care appointments following my treatment so that my healing may be monitored and so that Dr. Nakatani can evaluate and report on the outcome of my treatment upon completion of healing.

NO GUARANTEE OF TREATMENT: No guarantee or warranted results have been offered or promised. I realize that Dr. Nakatani may discover conditions that may require different treatment from that which was planned and I give my permission for those other procedures that are advisable in the exercise of the professional judgment to complete my treatment.

BISPHOSPHONATE DRUG RISKS: For patients who have taken drugs such as Fosamax, Actonel, Boniva or any other drug prescribed to decrease the resorption of bone as in osteoporosis, or for treatment of metastatic bone cancer, there is an increased risk of osteonecrosis or failure of bone to heal properly following any surgical procedure involving bone.

SECOND OPINION: If any significant doubt or questionable understanding persists after receiving explanations and/or reading this document, I have been encouraged to seek another opinion from a dentist knowledgeable in the area of periodontal dentistry prior to completing my deliberation and decision.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of this procedure and have received answers to my satisfaction. I recognize that it is my responsibility to fully inform Dr. Nakatani of the condition of my health and any and all problems thereto. I do voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and/or any results from the treatment rendered to me. The fee(s) for these services have been explained to me and I accept them as satisfactory. By signing this form, (1) certifies that I have read and understand the entirety of this document and (2) I am freely giving my consent to authorize Dr. Nakatani and/or all associates involved in rendering any services he/she deems necessary and advisable to treatment of my dental conditions, including any anesthetic agents and medications.

X _____
Name of Patient (Please Print)

X _____ X _____
Signature of Patient or Legal Guardian Date

As a part of this consent agreement, I give my personal pledge, as a healthcare professional dedicated to the well-being of my patients, to make every reasonable effort to assure that this patient receives the best possible care with the least possible risk.

Clifton E. Nakatani
Clifton E. Nakatani DDS MSD INC.

_____
Witness