DENTAL SQUARE

8920 Highway 50, Unit E9, Brampton, ON Phone: 905-915-8988

IMPACTION / SURGICAL EXTRACTION

Consent to Treatment

I____consent to treatment of myself and or _______________________________by _________________________. I acknowledge that I have been explained the nature of my /and or their problem and the potential treatments that could be used for this problem. I understand them to be as follows:

1. Root canal treatment to save the tooth (NA / Poor Prognosis)
2. Monitor if not hurting / troubling at this time (NA)
3. Operculectomy (Recurrent issues / Risks of Ling.n damage)
4. No treatment

I further acknowledge that the normal course of treatment with respect to surgery (treatment) has been explained to me as well as normal sequelae, risks and complications.

1. Bleeding, Swelling, Prolonged pain, Infection
2. Lip, Tongue temporary / permanent numbness
3. Broken roots, damage to adjacent teeth / fillings
4. Aspiration of root, teeth fragments
5. Dry socket (Bone pain) / Sinus perforation and / or infection
6. Soft tissue bruises and hematoma due to instrumentation and local anesthesia

In the event of occurrence of any of the above complications, I know that treating doctor may need to refer me to a specialist appropriately and the costs of such unexpected treatment would be paid by me.

I have moreover received written information with respect to what was explained to me, and have read this, understood it and had the opportunity to have my questions and concerns related to the prescribed treatment answered to my satisfaction.

I understand and agree to the fees involved with this treatment as outlined and agree to the financial aspects as one of my responsibilities.

Signature: Patient or Guardian: _______________________

Witness: _________________Date:________