SUMMERS AND JOHNSON PERIODONTAL PARTNERSHIP
BRIAN R. SUMMERS, D.D.S., M.S.
PATRICK L. JOHNSON, D.D.S.

CONSENT FOR EXTRACTION OF TEETH

The possibility exists of infection occurring after extraction of teeth or any dental surgery. When a lower tooth is extracted, there is always the possibility of complications that develop, which include but are not limited to: pain, infection, swelling, scarring, sensitivity, bruising, temporary or permanent numbness of the lower lip, tongue, chin or teeth. The doctor has also discussed with me the possibility of injury to the adjacent teeth and restorations in other teeth when any extraction is performed. In addition, when removing upper teeth, sinus complications may develop. Complications may include an opening into the sinus from the mouth, which may necessitate further surgery to close. There is also a possibility of rare and unpredictable complications.

I hereby authorize Brian R. Summers, D.D.S., M.S. and/or Patrick L. Johnson, D.D.S. and such assistants as they designate to perform necessary extraction or extractions for me, and to any other procedure, in their judgment, which may be necessary during the extractions. The effect and the nature of the extraction surgery to be performed, the risks involved, as well as possible alternatives of treatment have been fully explained. No warranty has been made by anyone as to the results which may be obtained. Any risk from non-treatment has also been explained.

I consent to the administration of anesthetics to be applied by or under the direction of doctors as to use such anesthetics as they deem advisable. I also understand that smoking tobacco or drinking alcoholic beverages and/or carbonated beverages may cause significant problems following these extractions.

I certify that I have had the opportunity to read and fully understand the terms and the words within the above document and feel that I have been informed adequately regarding the risk and the expectations of the procedure.

Printed Name of Patient or Parent/Guardian	Signature of Patient or Parent/Guardian	Date

Printed Name of Witness	Signature of Witness	Date