Pioneer Health Dental

Primary Tooth Extraction Consent Form

Patient Name: _____ Patient DOB: _____
I _____ (full name), as _____
(parent/guardian) for _____ (patient's full name), hereby authorise Dr _____ to perform the removal of _____
_____

The reasons for having it/them removed have been explained to me.

As with any treatment involving the body, there are some inherent risks and limitations.
Such complications include, but are not limited to:

+ Pain or discomfort may occur after the numbness wears off.
+ Bleeding. Some bleeding may occur if the blood clot from the whole where the baby tooth was is disturbed. Putting pressure on the whole with a piece of gauze should stop the bleeding.
+ Stretching of the corners of the mouth, resulting in cracking or bruising.
+ Possible damage to adjacent teeth as a result of the child making abrupt or uncontrolled movement during the procedure.
+ Incomplete removal of the roots. Pieces of the roots may be left behind if removing them poses a risk to the developing permanent tooth bud. In these cases, the roots usually resorb on their own.
+ Loss of space for adult teeth. When a baby tooth is lost early, the adult tooth may not be ready to move into position to fill the space. This can result in loss of space for adult teeth.

To my knowledge I have given an accurate report of the patient's physical and medical health history.

I accept the estimation of the fees as provided and agree to pay the account at the time of treatment.

Parent/Guardian Signature _____ Date _____

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