100 EAST LEHIGH AVENUE, CENTENNIAL TWO
PHILADELPHIA, PA 19125
215-707-0575 TELEPHONE
215-707-0848 FACSIMILE
www.specialsmilesltd.com

CHILD/CLIENT NAME: _________________________________ SURGERY DATE _____/_____/_____

INFORMATION ABOUT TOOTH EXTRACTION

Please read the following information, and discuss any questions you have with the attending dentist before signing consent. This list is intended to review the most common risks associated with tooth extraction, however is not limited to the following:

- Postoperative discomfort and swelling that may require several days of at-home recuperation
- Prolonged or heavy bleeding that may require additional treatment or surgery
- Injury or damage to the adjacent teeth, fillings, restorations or bridge work
- Postoperative infection that may require additional treatment including hospitalization and surgery
- Stretching of the corners of the mouth that may cause cracking and bruising and may heal slowly
- Restricted mouth opening and pain sometimes related to swelling and muscle soreness
- The decision to leave a small piece of root in the jaw, when its removal would require extensive surgery or risk of other complications
- Injury to the nerve under the lower teeth may result in temporary numbness, pain or tingling of the chin, lip, cheek, gums or tongue. This condition may persist for several weeks, months or in rare situations, may be permanent. In very rare cases, when the nerve to the tongue is injured, an alteration in speech or taste may occur
- Opening of the sinus (a cavity located above the upper teeth) requiring additional surgery

I understand that Special Smiles, Ltd is a licensed tenant of Temple University Hospital – Episcopal Division and that no services are being provided by Temple University Hospital – Episcopal Division.

ACKNOWLEDGEMENT AND CONSENT FOR TOOTH EXTRACTION

I acknowledge that I have read and understand the risks and consequences of tooth extraction as described above, and all questions have been answered to my satisfaction. I understand that I have the right to answers to additional questions that may arise during the course of the procedure.

I certify that I am the legal guardian of the above referenced child/client or have otherwise been empowered to give consent on behalf of the child/client for general anesthesia. This consent shall remain in force for 60 days after date signed or unless otherwise terminated by me.

_____________________________________ _____/_____/_____
Signature of Parent/Guardian Date

____
Name of Parent/Guardian (please print)

____
Relationship