Michael A. Pawlus, D.D.S., M.S.
(Practice Limited to Periodontics and Dental Implants)
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CONSENT FOR EXTRACTION(S)

I (print name) _____ hereby authorize Michael A. Pawlus to extract the following tooth(teeth):

Tooth # _____

Tooth # _____

I have been informed of the need to have the tooth (teeth) removed, and the details of the procedure have been explained to me. I fully understand them.

I have been told about the alternatives to the extraction(s), the risks and benefits.

I understand that following the extraction(s), there may be a period of numbness of the jaw, some swelling, bleeding, discoloration and discomfort.

I also understand that because of the position of the nerves in the area of the extraction(s) cannot be determined by x-rays, injury to the nerves may be unavoidable and may result in the loss of sensation to the chin, lips and tongue for a period of time. I have been told that although it is usual for the numbness to be temporary, it may, on extremely rare occasions, be permanent.

I further understand that my individual reaction to treatment cannot be predicted. If I experience any unanticipated reaction following the extraction(s), I agree to call the office as soon as possible.

I have been advised that the success of the surgery depends on my cooperation in keeping scheduled appointments, following home-care instructions (including oral hygiene and dietary instructions), taking prescribed medications and reporting any changes in the status of my health to the office.

No guarantees or assurances have been given as to the results that may be obtained. I have discussed the above with Dr. Pawlus and all my questions have been answered.

_____ _____

Patient's Signature Dr. Pawlus' Signature

_____ _____

Witness' Signature Date