Sconzo and Sciascia

Office Location: 1666 Marine Parkway, Brooklyn, NY 11234

Extraction Consent Form

The undersigned_____hereby authorize

Dr._____ to extract_____

I Understand that the following risks and hazards, though rather infrequent, may occur during or after surgery:

1. **Post-operative infection.**
2. **Excessive postoperative bleeding.**
3. **Post-operative discomfort, bruising and swelling of the surrounding tissues.**
4. **Loosening of adjacent caps and fillings.**
5. **Delayed healing (dry socket), requiring further treatment.**
6. **Possibility of a small root fragment being left in the socket, when removal would require excessive surgery.**
7. **Opening into the sinus (a normal cavity situated above the upper teeth).**
8. **Injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months, or in remote cases permanently.**

I have been given the opportunity to ask questions of the doctor and discuss alternative treatment (when applicable).

Patient Signature: _____ **Date**:_____

Signature of Guardian (if patient is a minor):_____

Doctor Signature:_____ **Date**:_____

Witness Signature:_____ **Date**:_____