CONSENT FOR PRIMARY TOOTH EXTRACTION

I hereby authorize and direct the doctor with the assistant(s) of his/her choice to remove (extract) the following primary ("baby") tooth/teeth: _______________ for _________________________(patient), including necessary or advisable anesthesia and medications, for the following reason(s): ____.
I understand that there are certain potential risks in any treatment plan or procedure, and although very unlikely, such operative risks include but are not limited to:

1. Postoperative discomfort and/or swelling that may necessitate one or more days of home recuperation.
2. Heavy and/or prolonged bleeding.
3. Bruising of the face (which is due to bleeding within the tissue, in which blood pigment works its way to the skin's surface).
4. Injury to adjacent teeth, fillings, crowns and/or hard or soft tissue.
5. Postoperative infection, requiring additional treatment.
6. Decision to leave a small piece of root in jaw, when its removal would require higher risk to the underlying permanent toot
7. Breakage of an instrument or bur tip, resulting in swallowing or aspirating (inhaling) the tip, possibly requiring medical treatment.
8. Allergic reactions (previously unknown) to any of the medications used.

I agree to cooperate completely with the recommendations of the doctor(s), while my child is under their care, realizing that any lack of the same could cause a less than optimum result.

I CERTIFY THAT I HAVE HAD AN OPPORTUININTY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE CONSENT TO TREATMENT, AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN BEFORE I SIGNED.

____ ____________________________
Parent's/Guardian's Printed Name Date

____ ______________________________
Parent's/Guardian's Signature Doctor's Signature