Consent Form for Surgical Removal the Embedded Tooth

Name: ..... Age: ..... HN: .....

I,....., hereby consent to undergo the surgical removal of the embedded tooth (tooth number……) as advised by Dr.……, as the tooth is unable to erupt into its normal position of functional properly in the oral cavity.

1. I have provided the information about the risks and complications including :

1.1 Dry socket (Alveolar Osteitis) : Inflammation of the tooth socket may occur, leading to prolonged pain. However, this condition typically improves with proper treatment.

1.2 Inferior Alveolar Nerve Injury : The procedure may cause injury to the nerve that supplies sensation to the lower teeth, lower lip, and chin on the affected side. This may result in numbness in these areas, which is usually temporary (lasting 6-12 months) but could be permanent in rare cases.

1.3 Lingual Nerve Injury : The nerve responsible for tongue sensation and taste may be affected, as it runs close to the lower wisdom tooth. Injury can occur from local anesthesia or the surgical procedure, leading to temporary (6-12 months) or, in rare cases, permanent numbness and loss of taste sensation.

1.4 Dental Root Fragment Retention : If the root tip is small (less than 1 mm), the dentist may decide not to remove it to prevent further damage to nerves or adjacent structures. The dentist will inform the patient of such a decision during the surgery.

1.5 Injury to Adjacent Teeth or Bone : The surgical procedure may cause accidental trauma to neighboring teeth or the surrounding bone.

1.6 Maxillary Sinus Perforation : If the upper wisdom tooth is close to the sinus cavity, there is a risk of creating an opening between the oral cavity and the sinus, or a tooth fragment may enter the sinus. Additional surgical intervention may be required to address this issue.

I, ..., have been fully informed by Dr. ..... about the surgical removal of the embedded tooth. I have had the opportunity to ask questions, and I understand the potential risks associated with the surgery. If any complications arise, I will receive appropriate medical care.

Based on the above information, I confirm that I have received sufficient details and voluntarily consent to the proposed treatment.

Signature: .....
(.....)
Treating Dentist

Signature: .....
(.....)
Patient / Authorized Representative
Relationship to the patient: .....

Signature: .....
(.....)
Witness

Signature: .....
(.....)
Witness

Date: ..... Time: .....

Note:

1. If the patient comes alone, please note “Patient came alone” in the witness signature field.
2. If the patient is under 18 years old, a parent or guardian must sign the patient/guardian field.