HALFMOON FAMILY DENTAL

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INFORMED CONSENT
SURGICAL / CROWN LENGTHENING
PROCEDURE

I have been made aware of my condition and the need for surgical extraction/crown lengthening on tooth_____.
I acknowledge that there have been no guarantees made to me concerning the result of the procedure. I understand and authorize my dentist to select alternative methods of treatment for conditions which were unknown before the dental procedure/surgery had begun or which were discovered during the procedure by my signature on this form.

I understand that there are inherent substantial risks and consequences that may be associated with any dental procedure. I understand that not every conceivable hazard can be listed and the following possibilities exist, however infrequent or rare. These include but are not limited to:

- Excessive bleeding with the possible need for additional procedures to achieve sufficient clotting and replenishment of lost fluids
- Blood clots anywhere in the body
- Infection
- Allergic reactions to medications or anesthesia
- Collection of blood or fluids requiring later drainage
- Injury to, or infection of, other organs, nerves or blood vessels
- Possible temporary or permanent numbness of the lip, tongue or cheek
- Fracture or dislocation of the jaw
- Perforation of the sinus area
- Entrance into the maxillary sinus to remove fragmented tooth or bone
- Pain, swelling and bruising

I understand the recommended treatment, the fee(s) involved, the risks of such treatment, the alternatives that have been explained to me and the risks of these alternatives and the consequences of doing nothing.

Patient Signature _____ Date _____