OBEIDDENTAL

OBEID DENTAL CONSENT FOR DENTAL EXTRACTIONS

I hereby give permission to Obeid Dental to perform Tooth Extraction(s) and such additional procedures as are considered necessary on the basis of findings during the course of said treatment. I have been informed of alternative treatment options, benefits and possible risks and after the dentist's explanation and I have chosen to proceed with treatment. I understand there are various inherent or potential risks that can occur as a result of said procedure(s) despite all efforts to the contrary which include but are not limited to:

1. Pain, swelling, bleeding, sensitivity, infection and/or bruising which may require additional treatment
2. Changes in occlusion (biting), jaw muscle cramps and/or damage to existing restoration which may require replacement
3. Damage to nearby teeth during said procedure that may require additional treatment
4. Drug reactions and incurred side effects
5. Post-operative bleeding or infection that may require additional treatment
6. Involvement of the nerve within the lower jaw resulting in temporary (but possible permanent) tingling and/or numbness in the lip, chin, tongue, gums, cheeks and teeth
7. Stiffness of the nearby muscles
8. Root tips may fracture and be left in place or could be displaced into the sinuses and/or spaces nearby requiring additional surgery
9. Aspiration and/or swallowing of foreign objects
10. Delayed healing (dry socket) necessitating additional post-operative care
11. Necessary removal of bone during tooth extraction.
12. Involvement of the sinus of the upper jaw requiring possible surgery for repair at a future date.

I understand that I should notify Dr. Obeid if any of these symptoms are present for more than 48 hours.

I understand that the administration of anesthesia and/or medications carry certain inherent risks, such as, but not limited to:

1. Bruising and/or numbness including the sites of the injection
2. Antibiotics may inhibit the effects of birth control pills and other methods of contraception must be utilized during the treatment period

The dental care and treatment to be performed has been explained to me and I understand what is to be done and that there is no warranty or guarantee as to any result and/or cure. I understand that I may consult with Dr. Obeid for a more complete explanation. This is my consent for said procedure(s), anesthetics and x-rays to be taken.

I hereby acknowledge I have completely read and understand the forgoing; have been given the opportunity to discuss this form and question the dentist concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment, and have been given satisfactory answers and agree to proceed with recommended procedure(s). I am aware the practice of dentistry is not an exact science and acknowledge that no promises or guarantees of results have been made nor are expected. This consent form does not encompass the entire discussion I had with the dentist regarding the proposed treatment.

I acknowledge full responsibility for the payment of these services and agree to pay for them in full at or before completion, unless other specific arrangements have been made.

Patient Signature (or Legal Guardian if applicable) Printed Name Date

Obeid Dental Team Member Date