Wisdom Teeth Removal

Status: active Form type: default Company: Acme Inc

WISDOM TEETH REMOVAL

Wisdom teeth removal is a common oral surgery procedure performed to extract one or more of the third molars, which typically erupt between the ages of 17 and 25. The aim is to address or prevent problems such as impaction, crowding, infection, or decay that can occur when these teeth do not have enough room to grow properly. The desired outcome is to relieve pain, prevent future dental complications, and maintain overall oral health. Risks inherent in the procedure include pain, swelling, bleeding, bruising, infection, dry socket, nerve injury (causing temporary or permanent numbness or tingling in the lips, tongue, or chin), sinus complications (for upper wisdom teeth), jaw stiffness, and adverse reactions to anaesthesia or sedation. Risks inherent in refusing the procedure may include worsening pain, infection, damage to neighbouring teeth, gum disease, cyst formation, misalignment of teeth, or the spread of infection to other areas. Risks specific to me will depend on factors such as the position of my wisdom teeth, proximity to nerves or sinuses, my medical history, and healing capacity. Expected benefits of the treatment include the elimination or prevention of infection, relief from discomfort, improved oral hygiene access, and prevention of future dental issues. Potential disadvantages of the treatment include the surgical risks noted above, a recovery period involving discomfort and dietary restrictions, and possible time off work or school. Alternative procedures and their pros and cons include leaving the teeth in place with regular monitoring (avoids surgery but may allow problems to develop) or less invasive treatments such as antibiotics or drainage for temporary relief (may not resolve the underlying issue). No treatment may be appropriate in cases where the teeth are healthy, fully erupted, and not causing problems, but this carries the risk of future complications. There are uncertainties regarding the likelihood of success, particularly in predicting whether all symptoms will be resolved, the speed of healing, and whether complications will occur. Follow-up treatment may include post-operative check-ups, suture removal, additional cleaning, or treatment of complications such as infection or dry socket. Informed Consent and Photography I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about: the aims/motivations for having the procedure and the desired outcome the risks inherent in the procedure the risks inherent in refusing the procedure the risks specific to me the expected benefits of the treatment the potential disadvantages of the treatment alternative procedures and their pros and cons – including the option of no treatment at all any uncertainties about and the likelihood of success of the procedure any follow-up treatment that may be required Clinical Photographs and Videos: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records. I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision. I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. All deposits and booking fees are non-refundable unless agreed to with the practitioner.

Do you understand the information you have been provided?

◯ Yes ◯ No

Do you feel sufficient information has been provided to you, to enable you to consent?

◯ Yes ◯ No

Has your consent been freely given?

◯ Yes ◯ No

Do you have any medical conditions?

◯ Yes ◯ No

Are you pregnant or breastfeeding?

◯ Yes ◯ No

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)?

◯ Yes ◯ No

Do you have an autoimmune disease?

◯ Yes ◯ No

Do you have any skin conditions?

◯ Yes ◯ No

Do you have any known allergies or have ever had anaphylaxis?

◯ Yes ◯ No

Do you have any active infection at the intended site of procedure?

◯ Yes ◯ No

Are you taking antibiotics or other prescription medications?

◯ Yes ◯ No

Is there any other Medical and/or Social History that we should know? If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

I will retain this information throughout the course of my treatment and refer to it as required.