
**GENESIS DENTAL CENTER BAHAMAS LTD.**
**Call Our office at: 242-393-2333 or 242-394-2333**

## TOOTH REMOVAL CONSENT FORM

I understand that **extraction of one or more teeth** has been recommended by my dentist.

I have been informed of any **alternative treatment options** (if applicable) as well as the possible consequences of not treating my dental condition. I understand that failure to seek treatment may result in, but is not limited to:

Infection or abscess formation
Swelling and pain
Malocclusion (changes or damage to how the teeth fit together)
Spread of infection that could affect other areas of the body

### Risks of Tooth Extraction

I understand that all dental, surgical, and anesthetic procedures involve risks. These risks include but are not limited to: post-operative infection or inflammation, bruising, and discomfort. Damage to adjacent teeth or existing fillings, Reactions to medications or anesthetics. Bleeding may require additional treatment. Possible intentional retention of small root or bone fragments if removal poses a risk *(These fragments may later surface through the gum tissue and require removal).* Delayed or impaired healing (such as **dry socket**), which may require multiple follow-up visits, Sinus complications, which may require further treatment or surgical repair, Fracture or dislocation of the jaw.

**Nerve injury**, which may result in temporary, partial, or permanent numbness or tingling of the lip, chin, tongue, or surrounding areas.

**Consent Acknowledgment:** By signing below, I certify that:
I understand the recommended treatment and associated fees.
I have been informed of the risks, benefits, and alternatives—along with the risks of declining treatment.
All my questions have been answered to my satisfaction.
I understand that **no guarantees** have been made regarding the outcome of the procedure.

**Signature:** _____

**Date:** _____