## DR. FAIZAN ABDUL HUSSAIN LAKHDIR

**CONSENT FORM FOR TOOTH EXTRACTION (Surgeon's Copy)**

| | |
|---|---|
| **Serial No** | **Date** |
| **Hospital / Clinic** | |
| **Patient Name** | |
| **CNIC / MR No.** | **Age** |
| **Gender** | **Contact No** |
| **Address** | |
| **Medical Conditions / Allergies / Medicines** | |

**Consent Statement**

I have been informed that I require removal of the above-mentioned tooth / teeth. The reason for extraction has been explained to me in simple words.

The procedure will be performed under **local anaesthesia**, which may be given **with or without epinephrine/adrenaline**, depending on my medical condition and the dentist's/doctor's clinical judgment.

I understand that local anaesthesia may cause temporary numbness of the lip, tongue, cheek, gums, or nearby area. I have informed the doctor about any history of allergy, heart disease, high blood pressure, diabetes, bleeding disorder, asthma, pregnancy, previous reaction to anaesthesia, or any medicines I am taking.

**Possible Risks and Complications**

I understand that although tooth extraction is commonly performed, complications can occur, including:

- Pain, swelling, bleeding, bruising, or infection
- Dry socket or delayed healing
- Injury to nearby teeth, filling, crown, bridge, or gums
- Broken tooth or retained root requiring further procedure
- Sinus communication in upper back teeth
- Temporary or rarely permanent numbness of lip, chin, tongue, or gums
- Jaw stiffness, limited mouth opening, or jaw joint discomfort
- Need for stitches, medicines, X-rays, referral, or further treatment

**Patient Declaration**

I confirm that the procedure, benefits, risks, alternatives, and possible complications have been explained to me. I have had the opportunity to ask questions, and my questions have been answered.

I understand that no guarantee has been given regarding the result. I give my consent for tooth extraction and for the use of local anaesthesia with or without epinephrine/adrenaline as considered appropriate.

| | |
|---|---|
| **Patient / Guardian Name** | **Patient / Guardian Signature** |
| **Doctor Name** | **Doctor Signature** |
| **Witness Name** | **Witness Signature** |

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| **Patient / Guardian Name** | **Patient / Guardian Signature** |
| **Doctor Name** | **Doctor Signature** |
| **Witness Name** | **Witness Signature** |