CONSENT FOR EXTRACTION

I, _____ hereby authorize Drs. Pomeranz/Argüello/ Neugeboren/ Marcuschamer to extract the following teeth from my mouth_____due to periodontal disease and/or future implant placement.

I have been advised that the consequences of not treating this condition include but are not limited to: infection, swelling, pain, periodontal disease, malocclusion, fracture of the jaw, and/or loss of bone. These complications may cause pain, destroy jawbone and teeth, and adversely affect overall health.

I understand that as a result of performing this procedure certain conditions may occur, including but not limited to: post-operative pain, swelling, discoloration of the face, and/or bleeding, numbness, swelling, infection, delayed healing necessitating frequent post-operative care, possibility of a small fragment of root being left in the jaw to avoid extensive surgery, possible involvement of the sinus during removal of upper molars which may require additional treatment at a later date, possible involvement of the nerve within the lower jaw during removal of lower molars resulting in temporary or possibly permanent tingling or numbness of the lower lip, chin or tongue.

I have been informed and understand that medication prescribed for me by Drs. Pomeranz/Argüello/ Neugeboren/Marcuschamer may contain narcotics, that such medications can have habit-forming or other side effects, and that such medications may cause drowsiness and a lack of alertness; therefore, I agree to neither drive an automobile nor operate machinery within at least four hours of taking such medication or if drowsiness or other side effects persist.

I certify that Drs. Pomeranz/Argüello/Neugeboren/Marcuschamer has fully informed me regarding the nature of the surgery to be performed, that I have read and fully understand the contents of this document and that Drs. Pomeranz/Argüello/Neugeboren/Marcuschamer has answered all questions that I have relating to my condition.

I understand that photographs, video, study models, radiographs and other diagnostic aids may be taken or used as a part of this procedure. I give my permission to Altura Periodontics for their use for educational, scientific and marketing purposes, including publication.

_____ _____

(signature of patient or legal guardian) (witness to signature)

_____

Date