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CONSENT FOR ENDODONTIC SURGERY

Patient's Name Date

You have the right to be informed about your diagnosis and planned surgery so that you can decide whether to have a procedure or not after knowing the risks and benefits.

Your diagnosis is: _____
Your Planned Treatment is:_____
_____
Alternative treatment: methods include: _____

If my doctor finds a different condition than expected and feels that a different surgery or more surgery needs to be done, I agree to have it done. That includes taking the tooth out if there was little chance of saving it.

All surgeries have risks. The most common risks for this procedure include the following:

1. Leaving a small piece of root in the jaw if a large surgery would be needed to take it out.
2. Bleeding, swelling, and discomfort after the procedure that may require at-home recuperation for a few days.
3. Bruising of mouth tissues or skin of face or lips in areas that may be far from the surgery site.
4. Injury to adjacent teeth or soft tissues.
5. Infection.
6. Numbness of the lip, chin, gums, cheek or tongue (including possible loss of taste sensation), usually temporary but sometimes permanent.
7. Fractures (breaking) of the jaw or thin bony plates of the jaw that may need more treatment.
8. A hole into the sinus (a hollow place above the upper jaw) that may need more treatment.
9. Loosening of or loss of dental fillings or caps.
10. Swallowing or inhaling of instruments or fillings.
11. Not being able to open the mouth as far as normal for several days sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).

Dental anesthetics used for these procedures, although considered safe, have certain associated risks and side effects that include: allergic reactions or other unexpected responses to drugs, heart irregularities, dizziness and nausea. The use of other drugs and medicines such as sedatives and antibiotics may also cause unexpected responses.

I agree to follow the instructions given to me during my treatment.

CONSENT

I understand that my doctor can't promise that everything will be perfect. I have read and understand the information in this form and give my consent to have the treatment. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date