Superior Endodontics
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Surgical Consent

I hereby give my free and voluntary consent to (and whomever may be designated assistants) to perform the following endodontic surgical and/or special procedure on (Patient Name.)

The purpose and nature of the surgical treatment has been explained to me. I have been informed of and understand the risks that are involved in the performance of treatment rendered. I understand that there is a possibility of complications developing during or after treatment and these have been explained to me. I understand that the following may be inherent or potential risks for the treatment I will receive:

> Swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; jaw muscle cramps and spasms; temporomandibular joint difficulty; loosening of teeth; crowns or bridges; delayed healing; sinus perforations; treatment failure; complications resulting from the use of dental instruments (broken instruments – perforations of tooth, root, sinus) medications, anesthetics, and injections; extruded gutta-percha and/or sealer; root perforations, ingestion of sodium hypochlorite or extrusion of sodium hypochlorite; fracture of porcelain crowns; discoloration of teeth; reactions to medications; and antibiotics may inhibit the effectiveness of birth control pills.

My doctor has explained that there is no method to accurately predict the gum and bone healing capabilities in each patient and no guarantee or assurances has been made as to the results that may be obtained. I fully understand that during and following the contemplated surgical procedure conditions may become apparent which warrant, in the judgement of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment such as bone grafts, biopsies and removal of fractured roots. I also approve any modifications in design, materials of care, if it is felt this is in my best interest.

I agree to the use of anesthesia as required and the appropriate disposal of any tissue removed.

To my knowledge I have given an accurate report of my physical and mental health history. I have read the above and understand that no treatment is without some measure of risk; and the risks of the proposed treatment have been explained to me. I prefer to undergo the surgical procedure in order to attempt to postpone the loss of my tooth. I hereby authorize the doctors and their assistants to perform the necessary endodontic procedures which have been described to me. I further request and authorize them to do whatever they deem advisable and necessary as a result of unforeseen circumstances. It has been explained to me nad I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted. I have been given the opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment.

_____ _____

(Signature of Doctor) (Signature of Patient)

_____ _____

(Witness) (Date)