Consent for Endodontic Procedures at Oceanside Endodontics

This document reflects my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic surgery to be performed by Dr. Diane McGinty, her associates and her dental assistants. I agree to the use of local anesthesia in these procedures according to Dr. McGinty and/or her associate's judgement.

I am aware that complications of microsurgery and anesthesia may include the following: pain, swelling, trismus (restricted jaw opening), infection, bleeding, sinus involvement, numbness or tingling of the lip, gum or tongue, which rarely are protracted, and even more rarely are permanent. Also, during endodontic treatment, there is a possibility of instrument separation within the canal or perforation of the tooth. I understand that it is my responsibility to report any symptoms to Dr. McGinty and/or her associates immediately.

Occasionally, medication will be prescribed by your endodontist. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or any other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, please call Dr. McGinty and/or her associates immediately. It is the patient's responsibility to report any changes in his/her medical history to Dr. McGinty and/or associates.

Endodontic treatment has a very high degree of success; however, as with any medical/dental treatment, there is no guarantee of complete success. I have been given the opportunity to question Dr. McGinty and/or her associates concerning the nature of the treatment, the inherent risks of the procedure(s), and the alternative(s) to such treatment(s). This consent form does not encompass the entire discussion I had with Dr. McGinty and/or her associates regarding his/her proposed treatment(s).

I understand that endodontic procedures are performed to save teeth that would otherwise require extraction. I understand that if I have a porcelain bridge/crown that porcelain may chip during the procedures. As we are a specialty practice, we do not have the restorative equipment that your general dentist has. **If we can restore your access with a simple restoration that is best for you, we will do that as an add-on to your endodontic procedure. We cannot always do this, but we will try to accommodate you.**

I hereby authorize the Doctor and/or their associates and his/her surgical assistant(s) to provide treatment.

Furthermore, I give Dr. McGinty and/or her associates permission to record, video tape and/or take photos of my procedure. These photographs may be used for the purposes of documentation, education, and/or teaching.

(If patient is under the age of 18, the signature of the parent or guardian is required.)

Note: All medical records will be kept strictly confidential

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Signature of Patient, Parent, or Agent Date