ROOT CANAL SPECIALISTS, P.C.

NAME_____
CHART NO._____

CONSENT FOR ENDODONTIC SURGERY

NOTE: You will be required to read this prior to treatment, but it does not commit you to treatment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic surgery performed by any of the endodontists employed by Root Canal Specialists, P.C., and any assistant(s) they may require. I agree to the use of local anesthesia, and/or nitrous oxide sedation (by special request only) depending upon the judgment of the endodontist.

I understand that the goal of this procedure is to surgically treat and possibly correct the inflammatory or diseased condition around my tooth (or teeth). *Although surgical endodontics has a very high degree of success, a perfect result cannot be guaranteed.* Due to local conditions of the tooth and surrounding tissues, and sometimes due to systemic conditions, a risk of failure or worsening of my condition may result despite treatment. Occasionally, a tooth which has had endodontic surgery may require retreatment or even extraction. I understand that the only alternative to endodontic surgery is extraction.

Complications of surgery and anesthesia may include swelling, pain, tissue ulceration, gum recession (shrinkage) over the involved tooth, looseness of the tooth, fractured teeth, bruising or discoloration of the skin of the face, trismus (restricted jaw opening), TMJ (joint) difficulties, infection, delayed healing, bleeding, sinus involvement, and numbness or tingling of the lip, gum or tongue for a few days which rarely is protracted and even more rarely is permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately.

At times, medication will be prescribed by the endodontist. I understand that medications for discomfort and sedation may cause drowsiness which can be increased by the use of alcohol or other drugs. I am advised against operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives, allergic reactions and intestinal problems and if any of these reactions occur, I am to call the endodontist immediately. I have been informed that antibiotics may interfere with the effectiveness of oral contraceptives (birth control pill). I understand that it is my responsibility to report any changes in my medical history to the endodontist immediately.

I have been given the opportunity to question the doctor concerning the nature of the treatment, the inherent risks of the treatment, and the alternative to this treatment. I hereby authorize Root Canal Specialists, P.C., and any assistant(s) they may require to provide treatment for condition described below:

TOOTH # _____THE PROCEDURE NECESSARY TO TREAT THE CONDITION HAS BEEN EXPLAINED TO ME AND I UNDERSTAND THE PROCEDURE TO BE:

PROCEDURE _____

PLEASE DO NOT WRITE BELOW UNTIL YOU HAVE TALKED TO THE DOCTOR TREATING YOU

DATE: _____ DOCTOR: _____ ASSISTANT:_____

I CERTIFY THAT I HAVE CAREFULLY READ THE ABOVE STATEMENTS ABOUT ENDODONTIC SURGERY AND THAT THE PROCEDURE TO BE DONE HAS BEEN EXPLAINED TO ME, AND THAT ALL QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I HEREBY CONSENT TO TREATMENT. ALL SIGNATURES MUST BE BY A PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE.

PATIENT'SSIGNATURE: _____