DOCS
DENTISTRY ON CATHERINE STREET

Consent for Surgical Endodontic Procedure

I have explained to the patient the nature of his/her dental problem, the nature of the surgical procedure, and the benefits to be gained from this approach compared to other alternatives. I have discussed with the patient the possibility of complications from the surgical endodontic procedure, including but not limited to infection, bleeding, or loss of sensation in the area (paresthesia). I have also informed the patient that no guarantees can be made concerning the results, and loss of the tooth may occur.

Tooth/Teeth Treated _________ Fee (Estimate) ________________________

Risks and Complications: I understand that the risks and complications associated with the use of local anesthetic include, but are not limited to: Nerve injury, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve, but in some cases may be permanent.

No Warranty or Guarantee: I understand that the doctor cannot guarantee the results of the procedure.

Consent to Unforeseen Conditions: During treatment, unknown conditions, such as discovery of changed prognosis for adjacent structures or teeth, may modify or change the original treatment plan. I therefore authorize the treating dentist to do additional or alternative procedures if, in his/her professional judgment, it is in my best interest.

Compliance with Self-Care Instructions: In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

I understand that excessive smoking and/or alcohol intake may affect healing and may limit the successful outcome of my surgery.

I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice good oral hygiene, keep all appointments, make return appointments if complications arise and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.

Supplemental Records and Their Use: I consent to photography, filming, recording, and x-rays of my oral structures as related to these procedures, and for their educational use in lectures or publications, provided my identity is not revealed.

Patient's Endorsement: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied. After thorough deliberation, I give my consent for the performance of any and all procedures related to endodontic procedures as presented to me during the consultation and treatment plan presentation by the dentist.

You or your responsible party will have the opportunity to sign an electronic copy of this form when you arrive at our office for your appointment.