

CONSENT FOR ENDODONTIC SURGERY

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 performed by the endodontist. I agree to the use of local anesthesia, depending upon the endodontist's judgment.

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. I understand that it is my responsibility to report any symptoms to Everett Endodontics 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 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, call Everett Endodontics immediately. It is the patient's responsibility to report any changes in his/her medical history to Everett Endodontics.

It has been explained to me, and I understand, that a perfect result from surgery is not guaranteed. I have been given the opportunity to question my endodontist 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 endodontist my regarding proposed treatment(s).

I hereby authorize Everett Endodontics to provide treatment for the condition(s) described below:

Furthermore, I give Everett Endodontics my permission to record, videotape and/or take photos of my procedure. These photographs may be used for purposes of documentation, education and/or teaching.

Patient Name

Patient Signature

Date

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