



CONSENT FOR SURGICAL TREATMENT

Please initial each item. If you have any questions, please ask Dr. Madison or Dr. Barr BEFORE initialing.

The aforementioned patient has been advised by Dr. Madison/Dr. Barr to have endodontic surgery on tooth /teeth#_____, in an attempt to save this tooth. Dr. Madison/Dr. Barr has discussed the need for surgical treatment on this tooth, other treatment options, pros and cons of different options, potential complications of surgery, potential post-operative problems, and prognosis. The following complications of a surgical procedure have been explained to me:

_____ Post-surgical pain, swelling and/or bruising may occur requiring prescription medications, including but not limited to analgesics (pain medications) and/or antibiotics.

_____ Inoperable defects in the root(s) being treated, including but not limited to fractures, post perforations and/or additional canals that may require extraction of the tooth.

_____ Complications associated with the administration of local anesthetics, including allergic reaction, fainting, heart palpitations, and/or overdose. Due to stretching of tissues and increase in fluid volume, bruising may occur which can last for several days / weeks.

_____ Communications with anatomic structures in the area of the surgery, including the maxillary sinus, floor of the nose, neurovascular structures, such as the mental foramen, mandibular canal, nasopalatine or greater palatine foramen which may cause complications and / or delayed healing.

_____ Excessive bleeding associated with vascular interruption. This may require additional suturing or referral to other dental/medical specialists for consultation or treatment.

_____ Paresthesia/anesthesia/tingling/numbness associated with manipulation of the nerve fibers in the surgical area. This maybe temporary or permanent and may require referral to other dental/medical specialists for consultation or treatment.

_____ Gum tissue may shrink when healing, leaving more tooth, root or crown margin exposed which may not appear esthetically pleasing.

_____ I understand that the most common potential complications of endodontic surgery are given above and that other complications may occur. Dr. Madison/Dr. Barr has discussed the potential problems associated with this surgical procedure. I accept the risks of the treatment. When indicated, a biopsy will be submitted for microscopic examination. The fee for this service is separate and not included in the surgical fee.

_____ I agree that this constitutes full disclosure, and it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions.

_____ I certify that I speak, read and write English and have read and fully understand this consent for surgery, have had my questions answered and that all blanks were filled in prior to my initials or signature.

Patient's (or Legal Guardian's) Signature Date

Printed Name

Doctor's Signature Date

Witness's Signature Date