Advanced Endodontic Care
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Informed Consent for Root Canal Surgery

I (we) hereby request and consent to the performance of the following operation: the administration of anesthetics deemed advisable for performing the operation or procedure; and extensions of the operation or procedure if considered advisable in performing the operation or procedure; and disposal of any tissue or body part related to the procedure, including scientific investigation excepting as noted below:

Operation or procedure____
____

Exceptions, if any:_______________________________________ (if none, write "none")

I acknowledge that I have had an opportunity to discuss with _______________________ the operation or procedure, its purpose and nature, reasonable alternatives, possible consequence of remaining untreated, and risks and possible complications. I understand that the practice of Dentistry is not an exact science, that I may involve the making of medical and/or dental judgements based upon the facts known at the time, that it is not reasonable to expect, anticipate nor explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgement, that no guarantee as to results have been made to nor relied upon by me, and I wish to rely on the dentist to exercise judgement during the course of the procedure or operation which he/she feels at the time, based upon the facts then known, are in my best interest.

NOTE: The most common and serious risks and complications of the intended procedure(s) as discussed with the patient:

Common Risks of surgery
Some bleeding, soreness, swelling, discoloration/bruising, gum shrinkage during healing, tooth mobility.

Uncommon Risks of Surgery
Loss of tooth, anesthetic sensitivity, sinus irritation, tingling sensation, numbness, medical complications.

Please ask questions of clarifications needed prior to treatment.

I have read this page and understand my treatment plan.
____

WITNESS TO SIGNATURE:

____________________________ Patient's Name:
____

Date: ________________________
____
Patient's Signature

____
____
Performing Doctor Signature Relationship or authority if not signed by the Patient

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