OAKWOOD ENDODONTICS

SURGICAL INFORMED CONSENT

This document signed and dated, is my consent for surgical root canal therapy associated with tooth/teeth number/s _____.
This document will allow the treating doctor to perform a diagnosis, and administer local anesthesia.

Surgical Endodontics may also include one or more of the following:

- ❑ Apicoectomy and Retrofilling (removing the root end and sealing the root)
- ❑ Biopsy
- ❑ Perforation Repair
- ❑ Hemisection
- ❑ Root Amputation
- ❑ Crown Lengthening Procedure
- ❑ Other

The alternative methods of treatment have been discussed with me.

- no treatment
- extraction
- retreatment

I have been informed of certain inherent and potential risks associated with this procedure which include, but are not limited to:

- paresthesia (numbness, tingling) for an indefinite amount of time
- injury to adjacent teeth
- sinus exposure (for upper teeth only)
- post-operative infection
- gum recession
- trismus (difficulty opening mouth)
- bleeding, swelling and discoloration
- other

If bone replacement therapy is necessary, a synthetic bone-like material will be placed at the site with an additional fee. In addition, a regenerative membrane may be placed with an additional fee.

If at any time during the procedure, the Doctor discovers the need to alter treatment, I authorize any additional treatment necessary.

I have had an opportunity to read this and have had all of my questions about this procedure answered to my satisfaction.

SIGNATURE:_____ DATE:_____

WITNESS: _____ DATE:_____