WEST SEATTLE ENDODONTICS
5016 California Ave. #101 Seattle, WA 98136

CONSENT FOR ENDODONTIC SURGERY

Patient's Name: _____

Date: _____

Proposed Treatment:

Endodontic surgery is a procedure aimed at saving teeth which may involve the surgical removal of soft tissue in the mouth, portions of roots of teeth and/or supporting bone structure. It may also involve filling of the root canal from the end of the root (a retrofilling) or the repair of a defect on the side of the root caused by a resorptive process or a root perforation. The degree of success of the surgery is variable, depending upon the condition being treated, and success cannot be guaranteed. Occasionally, despite all efforts, the tooth may require additional surgery, placement of a new root canal filling, or extraction. The most common alternative treatment to endodontic surgery is extraction. I understand that my alternative treatment options include: no treatment or extraction. If extracted, I understand that this tooth may be replaced by an implant, bridge, or partial denture.

I have been informed of the need for the endodontic surgery procedure(s) listed above and understand the possible complications of any treatment rendered, including, but not limited to:

• Postoperative discomfort, swelling and bleeding which may require additional treatment and several days of home recuperation.
• Postoperative infection requiring additional treatment.
• Injury to adjacent teeth and fillings and crowns
• Discoloration (bruising) of the mouth and/or skin of the face around the site of the surgery.
• Stretching of the comers of the mouth with resultant cracking and bruising.
• Restricted mouth opening for several days or weeks.
• Scar tissue along the incision line and gum recession or shrinkage around the necks of the involved teeth.
• Stomach upset from pain medication.
• Injury to the nerve underlying the teeth in the lower jaw, resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the side of the surgery. This may persist for several weeks, months, or in rare instances, be permanent.
• Opening into the maxillary sinus (a normal cavity situated above the upper teeth) which may result in an infection of the sinus and may require additional surgery or treatment.
• Injury to the temperomandibular jaw joint.

I understand the possible consequences of not receiving treatment in the near future, including the risk of infection, pain and the possible loss of the tooth. I agree to cooperate completely with the recommendations of those responsible for my treatment while I am under their treatment (i.e., postoperative instructions, dental home care and recall appointments), realizing that any lack of same could result in a less than optimum result.

I agree to pay the stated fees in effect at the time treatment is rendered and to present myself, or a minor child, for treatment and follow-up as discussed. I have had an opportunity to ask questions about the proposed treatment and any alternative procedures, and have had them answered to my satisfaction. I have read, understand, and now give permission for diagnostic and treatment services for myself or my minor child named above.

Patient name (print): _____

Patient (or Parent / Guardian) signature: _____

Date: _____