



CONSENT FOR ENDODONTIC SURGERY (not a root canal)

Patient's Name _____ Date _____

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 retro filling) 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 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
- Discoloration (bruising) of the mouth and/or skin of the face around the site of the surgery
- Stretching of the corners 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 the 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 temporomandibular jaw joint

If you are taking a blood thinner such as aspirin, this needs to be discontinued 7 days prior to the procedure, unless directed otherwise by your physician or Dr. Sabourin _____ (initial)

Please discontinue any NSAIDS 3 days prior to the procedure (ex. Advit or ibuprofen) _____ (initial)

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 with the recommendations of those responsible for my treatment while I am under 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 (or Guardian) signature _____ Date _____

Relationship to Patient _____ Witness _____

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