EA ENDODONTIC ASSOCIATES IN FRAMINGHAM WE WESTON ENDODONTICS

Consent for Endodontic Surgery and Associated Risks

Tooth # _____

__ Anterior __ Molar 1 Root __ Bone Replacement

__ Bicuspid One Root __ Molar 2 Roots __ Root Amputation

__ Bicuspid Two Roots

I hereby authorize Drs. Aboushala or Shlosman to perform an Apicoectomy. I understand the procedure is necessary to treat the condition(s) of this tooth, and I have been informed that extraction is an alternative method of treatment.

The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that in this specific instance such operative risks include, but are not limited to the following:

- Post operative discomfort and swelling that may persist for several days
- Some oozing of blood for several hours after the operation
- Post-operative infection requiring additional treatment
- Stretching the corners of the mouth with resultant cracking and bruising
- Restricted mouth opening for several days
- Injury to the nerve underlying the teeth resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side which may persist for weeks, months, or even permanently
- Opening of the sinus (a normal cavity situated above the upper teeth)
- Periodontal healing complications that may require periodontal treatment including surgery
- Scarring at the incision site
- Devitalization of the adjacent teeth that will result in the need for Root Canal Treatment and restorative or prosthetic treatment of these teeth
- Possible use of bone replacement

I have had the chance to have my questions answered. I understand that the success of this procedure cannot and is not guaranteed. In light of the above information, I authorize the doctor to proceed with surgical root canal treatment.

Patient Name: _____ Date: _____

Patient Signature : _____
(signature of guardian if patient is a minor)