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SPECIALISTS IN ENDODONTICS

INFORMED CONSENT FOR ENDODONTIC SURGERY

Endodontic surgery involves access to the tooth problem via an incision. This is usually done when it is impractical or impossible to treat your condition through other methods. Other treatment choices may include no treatment or tooth extraction. Risk of no treatment include, but not limited to, pain, swelling, infection, tooth loss and possible infection to other areas. Although endodontic surgery has a very high degree of clinical success, results cannot be guaranteed. On occasion, a biopsy of tissues may be indicated and is an additional fee not included with the cost of the surgery. Complications from surgery may include pain, swelling, infection requiring medication(s), bleeding, sinus involvement or numbness of the regional tissues.

I have had all options treatments and complications explained to me and have had an opportunity to ask and to have my questions and concerns answered. I fully understand the above statements in this form and consent to endodontic surgery.

_____ I give my permission for X-ray and photographic images of my teeth to be used as an educational example. I understand that the images will be anonymous and that no patient identifiers (name, age, sex, etc.) will be used.

All signatures must be by a parent or guardian if patient is under the age of 18.

_____ _____
Patient Signature **Date**

Denies Treatment _____ _____
Signature **Date**

_____ _____
Doctor Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have reviewed a copy of this office's Notice of Privacy Practices.

_____ _____
Signature **Date**

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because
_____.