Advanced Endodontics of Chicago

aechicago.com
312-291-9571

CONSENT FOR ENDODONTIC SURGERY

I hereby authorize Dr. Alayna Corden / Dr. Milton Davenport / Dr. Vikash Huliyar / Dr. Danny Kaplan / Dr. Samir Patel and any other agents or employees of Advanced Endodontics of Chicago to treat the condition(s) described below:

1. The procedure(s) necessary to treat the condition(s) has been explained to me, and I understand the nature of the procedure to be:

a) Surgical root canal therapy on tooth number(s)_____

b) Other:_____

2. I have been informed of possible alternative methods of treatment including no treatment at all and extraction.

3. It has been explained to me, and I understand that though success rates are very high, some teeth do not respond to treatment.

4. I understand that there are certain inherent and potential risks in surgical root canal therapy. Which include prolonged numbness of the jaw, tongue, or lip area (paresthesia). This is a rare complication and the vast majority are not permanent.

5. I understand that sinus exposure or dislodgement of a tooth root into the sinus is a rare possibility. This may result in the need for additional procedures.

6. My treating doctor and the staff of Advanced Endodontics of Chicago have provided me with answers to all of my questions concerning the nature of treatment; the inherent risks; and the alternatives to this treatment.

7. I understand that surgical root canal therapy may result in slight gingival (gum) recession, post-operative swelling and mild discomfort.

8. The possibility of a cracked or fractured tooth has been explained to me. I understand that detection of a cracked or fractured tooth may result in the need to have the tooth extracted.

9. I understand that the payment is due in full at the time of service.

10. All of the foregoing information has been explained to me. I understand the information and I consent to the treatment and agree to be responsible for payment of fees for treatment.

Patient

Signature: _____ Date: _____