RGV endodontics L.L.P

Endodontists

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PATIENT INFORMATION AND CONSENT FORM FOR ENDODONTIC SURGERY

I, _____ DOB: _____, hereby authorize, **Dr. Iván E. Rodríguez, Dr. Victor Luikham, or Dr. Ernesto G. Treviño** and their staff to perform upon me the following operation and procedures: Removal of the end of the root(s) (apicoectomy) and/or placement of a root-end(s) filling (retrograde filling) on tooth (teeth) number(s): _____

Phone _____ Email _____

Diagnosis _____ **Referring dentist**: _____

I understand that my doctor may discover conditions requiring different surgery from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgment. That would include extraction of the tooth if the prognosis is very poor.

Certain risks and complications are associated with endodontic surgery which include, but are not limited to:

1. Leaving a small piece of root in the jaw if its removal would require extensive surgery.
2. Post-operative bleeding, swelling, and discomfort that may require at-home recuperation for a few days.
3. Bruising of mouth tissues or skin of face or lips in areas sometimes distant from the surgery site.
4. Injury to adjacent teeth or soft tissues.
5. Infection.
6. Numbness of the lip, chin, gums, cheek or tongue, usually temporary but sometimes permanent.
7. Fractures of the jaw or thin bony plates of the jaw may require additional treatment.
8. Perforations into the sinus (a chamber in the upper jaw) which may require additional treatment.
9. Loosening of or loss of dental fillings.
10. Swallowing or inhaling of instruments or fillings.
11. Restricted mouth opening for several days, sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).

Dental anesthetics used for these procedures, although considered safe, have certain associated risks and side effects that include: adverse drug responses or allergic reactions, heart irregularities, dizziness and nausea. The use of other drugs and medicines such as sedatives and antibiotics may also cause adverse or unexpected responses.

I have given a complete and accurate medical history, including all medicines and drugs use. I also agree to fully comply with instructions given to me during the course of my treatment, and I acknowledge my responsibility to pay the fees involved and any other part of the fee that is not covered by my insurance company. No guarantees concerning the result of the planned operation have been given me, and I have been given the opportunity to have all questions answered to my satisfaction.

I hereby authorize **Dr. Iván E. Rodríguez, Dr. Victor Luikham, or Dr. Ernesto G. Treviño** to perform the treatment indicated above.

_____
Patient's Signature
Date _____

_____
Parent/Guardian Signature
Date _____

_____
Doctor Signature
Date _____

_____
Witness Signature
Date _____

BP: _____ **Pulse:** _____ **SPO2:** _____