ENDODONTIC
ASSOCIATES
Root Canal Therapy & Microsurgery

AUTHORIZATION FOR AND CONSENT TO SURGERY AND DRUG ADMINISTRATION

I hereby give permission to authorize Dr. Carnes, Dr. Hubble, Dr. Hoelscher or Dr. Crepps and whomever they may designate as their assistants to perform upon me the following operation and procedures:
Removal of the end of the root(s) (Apicoectomy) and/or placement of a filling at the end of the root(s) (Retrograde Filling) on ____________________________
and if any unforeseen condition arises in the course of these designated operations or procedures calling, in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize them to do whatever they deem advisable, including extraction of the tooth if, in their judgment, the tooth has a very poor prognosis.
I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In endodontic surgery, the most common of these complications include infection, post-operative bleeding, swelling and/or bruising, discomfort, sinus exposure and stiff jaws. Less common complications can include leaving a small piece of root in the jaw (if the removal of the root would require extensive surgery), loss of or injury to adjacent teeth and soft tissues (either oral or perioral), nerve injury (resulting in temporary but possibly permanent numbness of lip, chin, jaw or tongue), broken jaw, loosening or loss of dental fillings and swallowing or inhaling of instruments and fillings into lungs.
I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g. allergic reactions).
I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.
I realize that in spite of the possible complications, my contemplated surgery is necessary and is desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. In rare circumstances, hospitalization may become necessary to more effectively manage my care.
A full and complete explanation of all complications of surgery and anesthesia is available to me upon my request from the Doctor.

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Date Name (signed) Parent/Guardian (signed)

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Name (print) Witness

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