SJS Endodontics
& Microsurgery

Steven J Schmoldt, DDS
Diplomate, American Board of Endodontics
10 Forest Ave, Suite 201
Fond du Lac, Wi 54935
920-933-5332
www.sjsendo.com

ENDODONTIC SURGERY CONSENT

This is my consent to endodontic surgery and any other oral surgery deemed necessary or advisable during the planned operation. I understand that there will be a tissue sample taken for laboratory examination. I will be billed directly by the laboratory. I agree to the use of local anesthetic and analgesia. I am aware of the possible complications of the surgery, anesthesia, and other therapeutic drugs. Possible complications could include, but are not limited to:

1. Bleeding
2. Swelling
3. Pain
4. Infection
5. Paresthesia (Numbness)
6. Sinus Communication (Upper Teeth)
7. Floor of nose communication (Upper Teeth)
8. Tissue recession (The teeth may appear longer)
9. Loss of tooth

Possible alternatives to the proposed treatment include:
10. No Treatment
11. Retreatment
12. Waiting for more definite development of symptoms
13. Having the tooth extracted
14. Obtaining a second opinion

Risks involved in these choices might include pain, swelling, infection, loss of tooth, and infection to other areas.

Treatment will be done in a manner to minimize and avoid risks, but success cannot be guaranteed. I understand that endodontic surgery does not guarantee that I will retain the treated tooth (teeth) for the rest of my life.

_____ _____

Patient's Signature Date