Nona I. Breeland, D.D.S., M.S.
Practice Limited to Endodontics

SURGERY CONSENT FORM

______________________________________ has been advised by Dr. Breeland to have endodontic surgery on tooth number(s)_____________, in an attempt to save this tooth. Dr. Breeland has discussed the need for surgical treatment on this tooth, other treatment options, pros and cons of different options, potential post-operative problems, and prognosis. The following complications of a surgical procedure have been explained to me.

1. **Pain, swelling, and/or bruising may occur requiring prescription medications including but not limited to analgesics (pain medications) and/or antibiotics.**
2. **Inoperable defects in the root(s) being treated including but not limited to perforations, additional canals which may require extraction of the tooth.**
3. **Complications associated with the administration of local anesthetics including allergic reaction, fainting, heart palpitations.**
4. **Communication with anatomic structures in the area of the surgery including the maxillary sinus, floor of the nose, neurovascular structures such as the mental foramen, mandibular canal, nasopalatine or greater palatine foramen.**
5. **Excessive bleeding associated with vascular interruption. This may require additional suturing or referral to other dental/medical specialists for consultation or treatment.**
6. **Paresthesia/anesthesia (numbness of the jaw) associated with manipulation of the nerve fibers in the surgical area. This may be temporary or permanent and may require referral to other dental/medical specialists for consultation or treatment.**
7. **Short or long-term tenderness, soreness related to the temporomandibular joint (jaw joint).**

I understand that the most common potential complications of endodontic surgery are given above and that other complications may occur. Dr. Breeland has discussed the potential problems associated with this surgical procedure. I accept the risks of the treatment.

When indicated, a biopsy will be submitted for microscopic examination. The fee for this service is separate and not included in the surgical fee.

Please sign and date this form indicating that you have read and understand the information.
If you have questions about the treatment, please ask Dr. Breeland.

I GIVE MY PERMISSION FOR DR. BREELAND TO PERFORM THE ABOVE DESCRIBED ENDODONTIC SURGICAL PROCEDURE.

______________________________________ ______________________
Patient signature (Parent/ Guardian) Date

______________________________________ ______________________
Dentist signature Date

______________________________________ ______________________
Witness signature Date

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