SURGICAL ENDODONTIC THERAPY INFORMED CONSENT

I have explained to the patient the nature of their dental problem, the nature of the surgical procedure, and the benefits to be gained from this approach compared to other alternatives.

I have discussed with the patient the possibility of complications from the surgical endodontic procedure, including but not limited to infection, bleeding, alteration of sensation in the area, i.e. numbness, or sinus involvement.

I have explained that the patient may experience post operative discomfort or swelling which may require medications for several days. Further, although the surgery has a very high degree of success, it is still a biological procedure, and as such cannot be guaranteed and loss of the tooth may occur.

All questions were answered and the patient consents to the procedure.
_____D.M.D./D.D.S.

Dr._____has explained the surgical procedure to me and I consent to this procedure.

PATIENTS WITHOUT DENTAL INSURANCE

I understand that I am responsible for payment of the fees for services rendered.

PATIENTS WITH DENTAL INSURANCE

When treatment is started the staff will be asking me for a patient initial payment along with an insurance claim form which I must have filled out completely and accurately, assigning benefits to the attending dentist. The staff will then complete the dental portion and forward the claim to the insurance company on the day my surgical therapy is performed. After payment has been received from the insurance company, I will either receive a bill for any remaining balance or a refund check if the insurance company paid more than anticipated.

I further understand, that if, for any reason, my dental claim is rejected I am responsible for payment in full for all fees incurred.

Tooth Treated_____
Patient Initial Payment _____Fee_____

Signed By_____Date_____
patient, parent or guardian (please circle)
Signed By_____Date_____
Doctor
Signed By_____Date_____
Witness