the ENDODONTIC GROUP

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SURGICAL CONSENT FORM

I, _____ (the "Patient"), hereby give my free and voluntary consent to the Endodontic Group, its doctors and its assistants (collectively, the "Endodontic Group"), to perform the following endodontic surgery and/or special procedures.

The purpose and nature of the surgical treatment has been fully explained to me. I have been informed of and understand the potential risks that are involved in the treatment planned and have discussed these risks with the Endodontic Group. I understand that there is a possibility of complications developing during and/or after the treatment. These risks have been fully explained to me, and I have had the opportunity to ask the doctor any questions regarding the potential risks of the procedure. I understand that there are inherent or potential risks for the treatment I will receive, including without limitation:

> Swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, checks, and teeth, which is usually transient but on infrequent occasions may be permanent; reactions to injections; jaw muscle cramps and spasms, temporomandibular joint difficulty; loosening of teeth, crowns or bridges; delayed healing; sinus perforations; treatment failure; complications resulting from the use of dental instruments (broken instruments; - perforation of tooth, root, and/or sinus), medications, anesthetics, and injections; extruded gutta-percha and/or sealer; root perforations; ingestion of sodium hypochlorite or extrusion of sodium hypochlorite; fractured porcelain crowns; discoloration of teeth; reactions to medications; and antibiotics may inhibit the effectiveness of birth control pills. I further understand that this list is not all inclusive.

The Endodontic Group has explained that there is no method to accurately predict the gum and bone healing capabilities in each patient and no guarantee or assurances has been made as to the results that may be obtained.

I fully understand that during and following the surgical procedure, conditions may become apparent which warrant, in the judgment of the Endodontic Group, additional and/or alternative treatment, which is pertinent to the success of the treatment. These include, but are not limited to: bone grafts, tissue biopsies, removal of fractured roots, or the removal of the entire tooth and treatment of other teeth. I also approve any modification in the design, materials and/or care during the surgery, if it is determined that this is in my best interest.

I agree to the use of local anesthesia as required for the procedure and the appropriate disposal of any tissue removed during the surgery.

I confirm that I have provided the Endodontic Group with an accurate and complete report of my physical and mental health history.

I have read the above and understand that no treatment is without some measure of risk, and these risks have been fully explained to me.

I hereby authorize the Endodontic Group to perform the necessary surgical endodontic procedures which have been described to me. I further request and authorize the Endodontic Group to do whatever they deem advisable and necessary as a result of any unforeseen circumstances. It has been explained to me, and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted. I have been given the opportunity to question the doctor concerning the nature of the treatment, the inherent risks of the treatment and the alternatives to this treatment.

_____ _____

(Signature of Patient) (Date)