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FAUSTINO D. GARCIA, DMD
OSCAR J.PEGUERO JR., DMD
ALEXANDRA SAAB-PERAZA, DMD

One 7000 Place
7000 Southwest 62 Avenue PH-E
South Miami, FL 33143

T. 305 666 6104
F. 305 665 1136

admin@fdgendo.com
fdgendo.com

PATIENT INFORMATION AND CONSENT FORM FOR ENDODONTIC SURGERY

I, _____, hereby authorize, Dr. Faustino Garcia and his staff to perform upon me the following operation and procedures: Removal of the end of the root(s) (apicoectomy) and / or placement of a filling in the end (s) of the root (retrograde filling) on the tooth (teeth) number (s): _____
I understand that my doctor may discover conditions requiring different surgery from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgment. That would include extraction of the tooth if the prognosis is very poor.

Certain risks and complications are associated with endodontic surgery that include, but are not limited to:

1. Leaving a small piece of root in the jaw if it's removal would require extensive surgery.

2. Post-operative bleeding, swelling, and discomfort that may require at-home recuperation for few days.

3. Bruising of mouth tissues or skin of face or lips in areas sometimes distant from the surgery site.

4. Injury to adjacent teeth or soft tissues.

5. Infection.

6. Numbness of the lip, chin, gums, cheek or tongue, usually temporary, but sometimes permanent.

7. Fractures of the jaw or thin bony plates of the jaw may require additional treatment.

8. Perforations into the sinus (a chamber in the upper jaw) which may require additional treatment.

9. Loosening of or loss of dental fillings.

10. Swallowing or inhaling of instruments or fillings.

11. Restricted mouth opening for several days, sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).

Dental anesthetics used for these procedures, although considered safe, have certain associated risks and side effects that include: adverse drug responses or allergic reactions, heart irregularities, dizziness and nausea. The use of other drugs and medicines such as sedatives and antibiotics may also cause adverse or unexpected responses.

I have given a complete and accurate medical history, including all medicines and drug use. I also agree to fully comply with instructions given to me during the course of my treatment, and I acknowledge my responsibility to pay the fees involved and any other part of the fee that is not covered by my insurance company.

No guarantees concerning the result of the planned operation have been given me, and I have been given the opportunity to have all questions answered to my satisfaction.

I hereby authorize Faustino Garcia to perform the treatment indicated above.

_____ _____

(Patient's or Legal Guardian's) Signature Date

_____ _____

Doctor's Signature Date Date

_____ _____

Witness Signature Date Date