LAKESHORE
ENDODONTICS
J.JARED HARMON, D.D.S.

102 Village St., Suite B
Slidell, LA 70458
(985) 643-4600

800 C.M. Fagan Dr., Suite E
Hammond, LA 70403
(985) 345-2828

Consent for Root Canal Surgery

There are certain inherent and potential risks involved with the current procedure. Such operative risks include, but are not limited to:

1. Post operative discomfort and swelling lasting a few hours to several days. This may require several days of home recuperation.
2. Injury to adjacent teeth and fillings, which could require additional treatment.
3. For lower teeth there is risk of injury to the main nerve underlying the teeth, resulting in numbness, or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side. This may persist for several weeks, months or in remote instances, permanently. There may also be loss of taste.
4. For upper teeth there is a risk of opening into the sinus cavity, which is normally situated above the upper teeth. If this occurs there is risk for serious sinus infection that could require additional treatment.
5. Although extremely rare, serious post-operative infection of the head and neck could occur which may require additional treatment, including hospitalization.
6. Stretching of the corners of the mouth and face that may result in cracking and bruising.
7. Restricted jaw opening for several days after the procedure.
8. Recession of the gums, which could expose previously hidden crown margins and giving the appearance of "long teeth".
9. Scarring of the gums as a result of the surgical incisions.
10. Temporary increase in one's heart rate due to the anesthesia used to make the procedure comfortable.

The doctor has advised me that without treatment or surgery my present oral condition may worsen and in time cause concerns with my health, such as but not limited to swelling, pain, serious infection, malocclusion or bad bite, premature loss of teeth, premature loss of bone, chronic pain and discomfort.

The doctor has informed me of the alternative methods of treatment including root canal retreatment, extraction, no treatment at all, and the risks of non-treatment.

No guarantee or assurance has been given that the proposed treatment will be completely successful. Due to individual patient differences, there exists a *risk of failure*, which may lead to removal of the tooth. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my condition may occur sooner without recommended treatment.

I certify that I have read and fully understand this consent to surgery.

_____ _____
Date Signature of Patient or Patient's Guardian

_____ _____
Date Witness to Signature