INFORMED CONSENT FORM FOR APICOECTOMY SURGERY

1. I,____________________ _______ , hereby authorize and request that Dr._______ perform apicoectomy surgery on teeth number(s) ______________ .

2. Dr. _______ has explained to me that an apicoectomy is a surgical procedure involving the use of local anesthetic to numb the tooth and root structure and surrounding gum and bone. I understand that the administration of local anesthesia carries with it, its own inherent risks including but not limited to nerve damage, permanent numbness, temporary numbness, discoloration, rashes, swelling, infection, and even in rare instances cardiac death. The numbness can affect my chin, lips, gums, teeth, tongue, and surrounding tissue structures. I also understand that, in performing the apicoectomy surgery, after a local anesthetic is administered to me, Dr. ________ will then be performing a surgical procedure whereby he will be surgically cutting the root tip or root tips and that they will be removed. In performing the surgery, Dr. ________ will also remove the infected area and possibly, depending upon the condition of the remaining tooth structure, add a filling to the area. Dr. _______ has fully explained to me the surgical process and I understand that, after the incisions are made and the root tip or tips are removed, and possibly a filling inserted, that the site will have to be sutured up.

3. Dr. ________ has explained to me that the potential risks and complications to the apicoectomy surgery include the following: sinus perforation, hole in the sinus, trismus, swelling, sensitivity, pain, bleeding, infection, numbness, and/or tingling sensation, either temporary or permanent in nature, involving the lips, cheeks, tongue, chin, gums, teeth, and jaw,

changes in the bite, jaw and muscle cramps and spasm, tempormandibular jaw joint problems, myofacial pain dysfunction and muscular problems, loosening or damage to the tooth involved, loss of the tooth, damage to adjacent teeth including the loss of adjacent teeth, damage to crowns, fillings, and bridges, nerve damage, and bone damage. I understand further that, if any of these complications occur, that further surgery may be necessary to fix the problem.

4. I understand that apicoectomy surgery is not always successful but that the purpose of the procedure is to try to salvage the tooth. Many factors influence the treatment outcome including the patient's general health, bone support around the tooth, strength of the tooth including possible fracture lines, shape and condition of the roots, and nerve canals. I also understand that apicoectomies do, from time to time, fail, and that that is a material risk to the procedure. Should my apicoectomy fail, I understand that I would require a repeat procedure or even possibly the extraction of the tooth or adjacent teeth involved. I also understand that, by undergoing a apicoectomy, my problem may not be cured.

5. I also understand that, with respect to an apicoectomy, the tooth is in a weakened state compared to a natural tooth. That makes the tooth subject to the risk of fracturing or breaking during the surgery and also in the future. I understand that a tooth, which has had an apicoectomy, is at risk for further decay and even infection.

6. Dr. _________ has explained to me the alternative treatments to apicoectomy surgery including having no treatment at all, regularly monitoring the condition of the tooth, and even possibly extracting the tooth. I understand that, by doing nothing, or by monitoring the condition of the tooth, I run the risk of developing a severe infection and losing the tooth. Dr. _________ has also explained to me that the risks involved include, with an alternative such as an extraction, the risk of infection, numbness, dry socket, damage to the surrounding teeth, gums, bones,

muscles, and restorations. I reject these alternative treatments and request that Dr. _______ perform apicoectomy surgery upon me.

7. Dr. ______ has fully explained to me apicoectomy surgery and I have had a chance to have all of my questions answered. I understand that dentistry is not an exact science and that Dr. _________ has not guaranteed, promised, or warranted a successful result from the surgical procedure. In light of the above, I hereby authorize Dr. _______ to proceed with the apicoectomy surgery.

Date: ____________________

Signature of Patient:

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Witness: _____________________

Legal Guardian:

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