

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 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 they 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, temporomandibular jaw joint problems, myofascial 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, 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 an 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 that 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 with the alternative include 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:

Witness: _____

Legal Guardian:
