INFORMED CONSENT FOR APICAL SURGERY

Patient's Name ______________________________ Date __________

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR

_____I understand 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 acknowledge full responsibility for the payment of such services and agree to pay for them in full AT or BEFORE COMPLETION of treatment.

______Success rate - Although apical surgery has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. An apicoectomy can fail but is usually about 95% successful.

______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, 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 treatment/surgery may be necessary to fix the problem.

_____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 have the choice of EXTRACTION or doing nothing (understanding infection can occur, if there is no treatment at all)

______Swelling, sensitivity, pain and infection are possible during and after surgery (antibiotics may be needed.)

______I will be given injections of local anesthetics. Occasionally, during these injections, I understand that the needle can injure a nerve to my tongue or lip leading to temporary, prolonged, or permanent loss of feeling along the path of the nerve. Reactions to anesthetic injections may result in swelling, allergic reaction or hematoma (temporary discoloration of skin of face).

_____Jaw cramps and muscle spasms can occur (i.e., TMJ difficulty). Referred pain to ear, neck and head is possible for 2 to 3 days after surgery. It is not unusual to have biting sensitivity up to 4 weeks after surgery

______The tooth may be fractured, but not detectable (causing persistent biting pain)

______Antibiotics may cause diarrhea, abdominal cramps, colitis and allergic reactions (hives). CALL to notify the doctor of any of these complications. Antibiotics may reduce effectiveness of birth control pills (inform doctor).

______Temporary drowsiness/ lack of coordination from oral sedative medications/nitrous oxide (laughing gas) may occur.

______No guarantee or assurance can be given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. Due to individual patient differences, there exists a risk of failure, relapse, selective re-treatment, or worsening of my present condition despite the care provided. However, it is the doctor's opinion that therapy would be helpful, and that a worsening of my present condition would occur sooner without the recommended treatment (possibly leading to infection).

______I certify that I speak, read and write English and have read and fully understand this consent for treatment.

PLEASE ASK YOUR DOCTOR, IF YOU HAVE QUESTIONS CONCERNING THIS CONSENT FORM.

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

Doctor's Signature ______________________________ Date __________

Witness' Signature ______________________________ Date __________