Patient Name: _____

Date of Birth: _____

Informed Consent for Apicoectomy (root end surgery)

I. Recommended Treatment

I hereby give consent to Dr. _____ to perform Apicoectomy procedure(s) on me or my dependent as follows: _____

_____ ("Recommended Treatment") and any such additional procedure(s) as may be considered necessary for my well- being based on findings made during the course of the Recommended Treatment. The nature and purpose of the Recommended Treatment have been explained to me and no guarantee has been made or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with the Recommended Treatment. I also consent to the administration of local anesthesia during the performance of the Recommended Treatment.

II. Treatment Alternatives

Alternative methods of treatment have been explained to me, such as: _____

_____

but I wish to proceed with the Recommended Treatment described above.

III. Risks and Potential Complications

I understand that there are risks and potential complications associated with the administration of medications, including anesthesia, and performance of the Recommended Treatment. These risks and potential complications, include, but are not limited to, the following:

1. Drug reactions and side effects.
2. Post-operative pain, bleeding, oozing, soft tissue infection and/or bone infection.
3. Bruising and/or swelling, restricted mouth opening for several days or weeks, or, rarely, longer.
4. Loss/need for extraction of the tooth being treated, at the time of this surgery, or in the future.
5. Damage to, or fracture of, adjacent teeth or tooth restorations.
6. Delayed healing, necessitating post-operative care.

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7. Possible involvement of the sinus during procedures on upper posterior teeth, which may require additional treatment or surgical repair at a later date.

8. Possible injury of the nerves of the lower jaw during procedures on lower teeth resulting in temporary or permanent tingling/numbness/pain (possibly of an electric shock nature) of the lower lip, chin, tongue or other surrounding structures, with potential alteration or loss of taste.

9. If you are taking medications to make your bones stronger (such as bisphosphonates) or if you have received radiation therapy to the head or neck area for tumors/cancer, then you are at a higher risk for poor bone healing or bone loss that may never completely resolve and which may require surgery or other treatment.

10. As a result of the Lidocaine injection or use of other local anesthesia, there may be swelling, jaw muscle tenderness or even resultant tingling/numbness/pain (possibly of an electric shock nature) of the tongue, lips, teeth, jaws and/or facial tissues, which is typically temporary, but in rare instances, may be permanent; this may include alteration or loss of taste.

11. Pain and/or limited movement of the jaw joint, either of a temporary or permanent nature, which may require further treatment.

Signature: _____ Date: _____

Patient/Parent/Guardian

Relationship (if patient a minor): _____

Witness (signature): _____