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INFORMED CONSENT FOR ENDODONTIC SURGERY (APICOECTOMY)

On Tooth number (s):_____

My doctor has advised me that I will need to have an apicoectomy because the area surrounding the root tip has become infected or has root fractures. I hereby authorize Dr. _____to perform an apicoectomy to fix this problem in the hope of avoiding the need to extract the tooth.

I UNDERSTAND that APICOECTOMIES include possible inherent risks such as, but not limited to the following:

- Numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face (including possible loss of taste sensation), usually temporary but sometimes permanent.
- Post-operative bleeding, bruising, swelling; normally will subside after a few days.
- Adverse healing may result in but may not be limited to root fracture, infection, and cyst formation.
- Sinus or Mandibular Canal Involvement: Even though a rare occurrence, there is a slight possibility that the Maxillary Sinus or the Mandibular Canal may be perforated, or the nerves emanating from the Mental Foramen may be traumatized during the surgical procedure involved with removing the apices of the infected teeth.
- Injury to adjacent teeth or adjacent roots.
- Even though the surgical procedure is properly performed, there exists the possibility that the attempt to preserve the tooth will fail due to the tooth and tissues not responding as they should, thereby necessitating extraction of the tooth.

It is my responsibility to seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given to me.

Dental Anesthetics used for these procedures, although considered safe, have certain associated risks and side effects that include: adverse drug responses or allergic reactions, heart irregularities, dizziness and nausea. The use of other drugs and medicines such as sedatives and antibiotics may also cause adverse or unexpected responses.

I have given a complete and accurate medical history, including any medicine and drug use. I also agree to fully comply with instructions given to me during the course of my treatment.

No guarantees or promises have been made to me concerning the results of treatment to be rendered to me. I understand that the need for additional treatment to save my tooth might result in additional costs.

I hereby authorize the Aesthetic Dental & Implant Center of Central Park South to render the treatment indicated above.

_____ _____

Signature of patient, legal guardian, or authorized representative Date

_____ _____

Signature of witness Date