

INFORMATION INFORMED CONSENT

APICOECTOMIES AND APICAL SURGERY

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

- 1. Injury to the nerves:** This would include injuries causing numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face. This numbness could occur and may be of a temporary nature, lasting a few days, a few weeks; a few months; or could possibly be permanent, and could be the result of surgical procedures or anesthetic administration.
- 2. Bleeding, bruising, swelling:** Bleeding may last several hours. If bleeding is profuse, you must contact us as soon as possible. Some swelling is normal, but if severe, you should notify us. Bruises or hematomas may persist for some time.
- 3. Infection:** No matter how carefully surgical sterility is maintained, it is possible, due to existing non-sterile or infected oral environment, infections may occur postoperatively. At times, infections may be of a serious nature. Should severe swelling occur, particularly accompanied with fever or malaise, attention as soon possible should be received.
- 4. Sinus or Mandibular Canal Involvement:** In some cases, the roots of the teeth that are going to be apically treated lie in closer apposition to the Maxillary Sinuses or to the Mandibular Canal, including the Mental Foramen than they appear to be radiographically. 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.
- 5. Injury to adjacent teeth or adjacent roots:** There is a possibility of injury to an adjacent tooth or to roots of teeth during the procedure. If an adjacent tooth or roots of teeth are inadvertently nicked or otherwise damaged during the surgical procedures, conventional endodontic treatment, endodontic surgery, or extraction may be required.
- 6. Bacterial Endocarditis:** Because of normal existence of bacteria in the oral cavity, the tissues of the heart, as a result of reasons known or unknown, may be susceptible to bacterial infection transmitted through blood vessels, and Bacterial Endocarditis (an infection of the heart) could occur. Pre-existing conditions causing valvular dysfunction are the most likely cause of this complication. It is my responsibility to inform the dentist of any heart problems known or suspected.
- 7. Failure:** 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.
- 8. Unusual reactions to medications given or prescribed:** Reactions, either mild or severe, may possibly occur from anesthetics or other medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics that may be necessary to control infection can render these contraceptives ineffective. Other methods of contraception must be utilized during the treatment period.
- 9. It is my responsibility to seek attention should any undue circumstances occur postoperatively and I shall diligently follow any preoperative and postoperative instructions given me.**

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of surgical treatment known as Apicoectomy and have received answers to my satisfaction. I have been given the option of seeking care from any oral-maxillofacial surgeon; a periodontist; and/or endodontist. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning my recovery and results of treatment to be rendered to me. The fee(s) for this service have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. _____ and his/her associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

Patient's name (please print)	Signature of patient, legal guardian or authorized representative	Date
Tooth No.(s) _____	Witness to Signature	Date